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SKYROCKETING PRESCRIPTION DRUG COSTS: EFFECTS ON SENIOR CITIZENS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

LEWISTON, ME

APRIL 15, 1992

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SKYROCKETING PRESCRIPTION DRUG COSTS: EFFECTS ON SENIOR CITIZENS

WEDNESDAY, APRIL 15, 1992

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Lewiston, ME.

The Committee met, pursuant to notice, at 9:30 a.m. in the City Council Chambers, first floor, Lewiston City Hall, Lewiston, Maine, Hon. William S. Cohen [Acting Chairman of the Committee] presiding.

Present: Senator Cohen.

Also present: Mary Berry Gerwin, minority staff director/chief counsel and Tracy Gay, professional staff.

Senator COHEN. The Committee will come to order.

Ladies and gentlemen, thank you all for coming to the hearing this morning. It is a pleasure to welcome you to this hearing on behalf of the Special Committee on Aging. We are going to hear from some of the citizens who have written to me during the last several years. They are going to describe some of their personal experiences they have had with the tremendous rise in the cost of prescription drugs.

First let me thank all of our witnesses for coming from around the State to testify on how the high cost of prescription drugs has affected your lives and the lives of friends and others you know.

More and more, senior citizens and families are being terrorized by the high cost of prescription drugs, and the anguish over how to pay for necessary medications has truly become a recurring financial nightmare for far too many Americans. Over the past decade, prescription drug costs have increased over three times the general inflation rate, and these increases have been rapidly outpacing the ability of the average person to pay for his or her medication. Families with no insurance or those with no prescription drug coverage are dreading trips to the doctor for fear that he or she is going to prescribe a medication which they simply can't afford to buy.

I've received literally hundreds of letters from Maine citizens who have shared with me their despair over the costs of their medications. Not even Stephen King could conjure up the financial horrors faced daily by these people. For example, a 14-year-old boy from southern Maine who had a kidney transplant had his prescriptions paid for by Medicare for 1 year. Now his family has to pay $1,200 a month out of pocket for his drugs, and this financial burden is going to continue for the rest of this young man's life.

While the young and the old alike are affected by high drug costs, the financial burden is especially devastating to senior citizens who are living on fixed incomes. Prescription drug costs are

now the highest out-of-pocket medical expense for three out of four elderly citizens. Recently, the American Association of Retired Persons surveyed older Americans about drug costs. One out of seven senior citizens surveyed responded they have failed to take their medication because it's simply too expensive. In addition to being major consumers of prescription drugs, many elderly do not have prescription drug coverage, and Medicare doesn't cover out-patient prescription drugs.

As a result, over half of the elderly in America face potentially catastrophic out-of-pocket prescription drug expenses because they have no Medigap coverage or because that coverage doesn't include prescription drugs.

Some of you who have contacted me are here today to tell your own story, but first I want to share just a couple of the many stories that I've received from senior citizens all over Maine.

I had a couple who wrote to me from northern Maine, "We are both retired and live on Social Security. We have to cut down the amount of medication we are supposed to take because it would cost more and we cannot afford it."

A widow from central Maine wrote to me, "I am glad to see someone is interested in trying to curb the cost of prescription drugs. I am living on a fixed income and wonder each month what food I can cut to pay for my prescriptions."

Another couple wrote, "One of my prescriptions has increased from $11.75 in 1988 to $43.05 in 1992. Something has to be done to stop this. If not, people will die due to lack of medicine. We cannot continue to pay these prices."

A senior citizen from Lubec wrote, "There are people who don't get their prescriptions filled because they don't have the money. Those who do take only half of the prescription and make it do, because they can't afford them."

A senior citizen from Greene wrote to me saying he was spending about $160 a month for medication for arthritis, and he stopped taking it because he "could tolerate the pain better than the expense."

Another wrote, "I know people who are trying to either cut down or do without important medications, and this means that sooner or later they will end up in the hospital or on welfare."

Finally, a woman from Portland wrote, "It seems like I just endorse my Social Security check to the drugstore."

I could go on with literally hundreds, if not more, of these letters of this same caliber, but it's clear to me from these comments that the problem of escalating prescription drug prices is far-reaching and so severe that people in our own neighborhoods are forced to make life or death decisions on whether to eat, keep warm, or take their medications.

While our seniors are scrimping and digging deeper and deeper in their pockets to pay for these drugs, pharmaceutical companies are reaping the benefits of generous tax subsidies with one hand and continuing to raise the price of their products with the other, giving them a two-fisted advantage over a powerless public.

The annual profit margin of the drug industry is now more than three times the profit margin of the average Fortune 500 company.

There's nothing wrong with generating profits, but they shouldn't be generated at the expense of the most vulnerable in our society.

We have to raise the question, what are the drug companies doing with some of these profits? A number of them would have us believe that the high prices are necessary for research and development to bring new drugs to the market and there's a good deal of truth to that. Unfortunately, however, that's not always the case. As their prices go up, so does the advertising efforts on behalf of the industry.

The Senate Aging Committee and the Senate Labor and Human Resources Committee have uncovered some rather startling marketing practices by some drug companies. Many of the dollars that the drug manufacturers claim are being spent on researching new products are actually spent on expensive marketing and promotional campaigns. Until recently, the drug manufacturers have wooed doctors to prescribe their products with all-expense-paid "educational seminars" at resorts, lavish vacations, and even cash payments.

The Food and Drug Administration found evidence that one major drug company has been offering free dinners and $100 gift certificates to doctors to promote drugs that have not even received approval by the FDA. While the doctors do not prescribe the unlicensed products, these offers by the drug companies have been attempts to prime the doctors to prefer their drugs once the products become available on the market.

I have here some examples of how some drug companies are spending your money. The drug company representatives send doctors promotional items to try to get the doctors to prescribe their products. We have "colder holders", a mug, a notebook, a diary for doctors, gym bags, and other items. These and many items like these have been supplied to doctors, and I have one doctor who received all of these items in just a 3-month period.

This is just some evidence, of the appalling fact that last year the industry spent $10 billion on marketing, which was actually $1 billion more than the industry spent on research.

We have watched for far too long as the industry has taken advantage of the public who is dependent on their products. This is not a situation where the consumer has a choice. If there's no generic for the drug you need, you're out of luck. You have to pay the company's high price, and Americans now, I should point out, pay the highest prices in the world for prescription drugs.

Last November I joined with the Chairman of the Senate Special Committee on Aging, Senator Pryor, and introduced legislation to address the rising cost of prescription drugs. Our bill establishes incentives for the drug manufacturers to keep their prices under control by reducing nonresearch tax credits for the companies that increase their prices faster than the general rate of inflation. Over 40 national groups, representing business, unions, consumer groups, insurance agents, health care professionals, and most importantly our constituents, support this legislation to curb the ever-escalating costs of prescription drugs.

Over the next few years, Congress will continue to debate the need for health care reform and the steps that have to be taken to contain the rising cost of health care. Acting now, or at least start-

ing the debate now, on how to stem the high prescription drug costs would be an important place for us all to begin. It would be a tremendous relief to the millions of senior citizens nationwide.

We should never underestimate the importance of new drugs to help the devastating illnesses of old age such as cancer, Alzheimer's and heart disease, but unfortunately we're faced with a good news/bad news situation. The good news is that we have the ability to save lives with remarkable drugs. The bad news is that you cannot afford them. And that is what more and more people are facing on a daily basis.

Finally, there may be some representatives from the pharmaceutical industry in the audience today, and I'd like to make it very clear that this legislation makes no attempt to minimize the importance of the drug industry to our Nation's economy or the importance of the industry to the health and well-being of every citizen, regardless of age. It is not an attempt to impose price controls on the industry, as virtually every other industrialized nation does. Most other Western nations impose fairly stringent price controls. We do not do that, nor does the legislation that I introduced with Senator Pryor attempt to do that. What we are doing is simply pointing out to the industry that it cannot continue to ask the taxpayer to subsidize fairly generous tax benefits that have no relationship to research and development and that go well beyond the research and development tax base and at the same time allow prices to continue to rise well above the rate of inflation. It is an incentive, hopefully, for the drug industry to curb the rise in their costs and charges on a voluntary basis, and if they don't, then they cannot expect the taxpayer to continue to subsidize those benefits that are provided for them locating their industries down in Puerto Rico.

So with those opening comments, I want to welcome the first panel of witnesses, who have traveled across the State to be with us today to tell their personal stories on how the costs of prescription drugs are affecting their lives. We're going to hear from Mr. George Roy of Biddeford, Mr. Wilfred Graham from Portland, Mrs. Gertrude Zimmerman from Brunswick, and Mrs. Lillian Trumble from Lisbon Falls, and, of course, Mr. Al Rawley from Bangor.

Mr. Rawley, would you like to begin?

STATEMENT OF AL RAWLEY, BANGOR, ME

Mr. RAWLEY. Thank you very much.

My name is Al Rawley, Senator, and I'm almost 74 years of age. I'm retired and living with my wife, Aileen, and our 29-year-old retarded son, Alan, on Holland Street in Bangor.

In 1982 I suffered my first stroke. I lost the sight in my left eye and much of my voice quality. Because I was an on-the-air broadcaster for 50 years, this was catastrophic. So I left broadcasting and lost my income. It was then that I first encountered prescription drugs and the cost of those drugs. From that time to the present, my income has been solely from Social Security. The next encounter with the cost of prescription drugs was Aileen suffered a skin disease brought on by ticks and fleas. This meant an added drain on our funds, because the special medications, salves, and weekly

scalp treatments are very expensive. Meanwhile, the cost of my Beta Blocker medication was steadily climbing. Next, I suffered severe angina, resulting in a quadruple bypass operation. Now my prescription drugs were expanded, and the cost was becoming really unwieldy. Next, Aileen suffered a severe stroke, was hospitalized, and was prescribed many more drugs, one of which costs $85 a month. Finally, because of my stroke in 1982, it was decided that I should undergo an operation on my one remaining carotid artery to prevent a massive stroke, because Aileen and my 29-year-old retarded son depend on me.

Aileen's and my Social Security income is $1,014 a month. Our prescription drugs cost us a minimum of $160 a month—that's a minimum of $160 a month—not counting the cost of nonprescription drugs suggested by our physician. A case in point: I asked the doctor for a nasal spray so I could sleep better at night, and my good friend, Bill, who you will hear from later, sent me this nasal spray. It's $35 for a nasal spray, and that's a bit much. I'd rather stop——

Senator COHEN. We're going to take that up with Bill Miller when he's up here. [Laughter.]

Mr. RAWLEY. All told, our actual cost for medication is between $175 and $200 a month. This cost, augmented by mandatory examinations and tests, leaves us in a financial hole which is getting deeper as the medication costs increase. The final blow is the examinations, such as dental examinations, which must be denied—we're stopping them entirely—for fear of more pills and more bills.

Thank you very much, Senator, for giving me this opportunity. I'd be glad to answer any questions you have.

Senator COHEN. We'll go through the entire panel, and I'll have some questions for each of you.

Mr. Roy.

STATEMENT OF GEORGE A. ROY, BIDDEFORD, ME

Mr. ROY. My name is George Roy, and my wife is Theresa Roy. I'm 71 years old, and my wife is 67.

My wife had a heart attack in October 1979 and had open heart surgery in August 1980. The surgery has not proven helpful. She has been on prescription drugs since 1979 and has been increasing the drugs over the years. She is now taking 21 prescribed medications, which amounts to 48 pills daily, plus two inches of nitrobid paste four times a day. She takes three types of inhalers with two puffs four times a day. These inhalers cost $29.73 apiece. My wife also takes Ambenyl for chronic bronchitis. A bottle of Ambenyl cost $18.80 in 1990, and now it's up to $45.11 in 1992. This medication has to be refilled every week. She received also a transplant pacemaker in September 1989.

I also had a heart attack in January 1981 and have been on medication since then. I received a pacemaker in October 1985. I take five different pills, and I take 15 pills a day. One of the pills I take is Cardiogain. I take six pills of those daily. Three years ago the cost of 200 pills was $119.53. As of 2 weeks ago, I had it refilled, and it cost $198.74, an increase of $79.21. I also take Cardizein. One

hundred pills used to cost $28.62, and in March 1992, I paid $39.81, an increase of $11.19.

In 1991 the total cost of prescription drugs for my wife and I was $7,405.97. In addition, over-the-counter drugs cost approximately $50 a month. So in 1991 drug costs totaled over $8,000.

Since 1986 I have spent about $48,000 out of my pocket without any help. We are not covered for prescription drugs under Medicare or under our Blue Cross/Blue Shield supplemental health insurance policy. We are now each paying $60.75 a month for our supplemental insurance. This totals $1,458 per year. In addition, a Medicare Part B premium of $31.80 is deducted from each of our Social Security checks every month. This totals $763.20 a year.

My Social Security check is $682 per month. My wife's Social Security is $411 per month. Together we receive $13,116 a year from Social Security. I cannot qualify for the State Low-Cost Drug Program because I receive $1,000 over the limit, but my Social Security check only covers the amount of the prescriptions we buy. We are left with just my wife's $411 check to live on and it isn't enough for food, utilities, heat, taxes, and insurance, so we are running out of money.

I don't want to sell my house; I need a place to live. I hope that I can get some relief to help me, because we have to take these medications.

My wife has been going to the doctor every week for the last 6 months, and the doctor's charge is $76.75. Medicare approves $63.50 and pays 80 percent. Blue Cross/Blue Shield pays the other 20 percent, but it costs me $13 every week out of my pocket for the doctor's bill.

My wife goes to the hospital two to three times a year, and the doctor charges between $600 and $800, depending on the stay. She never stays less than 10 days. Medicare pays $500, and I must pay the rest out of my own pocket. So when you add all of these medical expenses up, it costs about $9,000 a year for medical expenses.

Right now I'm running out of money, and I need some help.

Thank you.

[The highlights of Mr. Roy's statement follow:]

Memorandum April 10, 1992

To: Tracy (for WSC)
From: Diane/Bidd
Re: Statement of George Roy
Drug Hearing

Highlights of Mr. Roy's statement:

Both Mr. and Mrs. Roy have heart condition.
Mrs. Roy has several other serious illnesses: chronic bronchitis, cancer.

Monthly Income from Social Security:

G. Roy: $682.; T. Roy: $411

TOTAL SOC.SEC. CHECKS FOR YEAR: $13,116.*

($13,879 before Med. B prem. deducted)

*Medicare B premiums previously deducted

Medical Expenses:

Prescription drugs:	$615.
Over the counter:	50.
Total Monthly	$665.

TOTAL DRUG COSTS FOR YEAR: $8,000.

Monthly Health Insurance Costs:

Medicare B Premiums @$31.80:	$63.60*
Supplemental Blue Cross:	$60.75
Total Monthly	$124.00

TOTAL HEALTH INSURANCE COSTS FOR YEAR: $2,221.

PRESCRIPTION DRUG COST ESCALATION:

Examples:

Bottle of Ambenyl for Mrs. Roy's chronic bronchitis:
(Mr. Roy will have sample bottle)
1990: $18.80
1991: $29.73
1992: $45.11

200 pills of Cardiogain for Mr. Roy's heart condition:

1990: $119/53
1992: $198.74

ARTHUR M. SCOTT, JR., M. D.
37 AMHERST STREET
BIDDEFORD, MAINE 04005

TELEPHONE 282-0881

THERESA ROY MEDICATION LIST 12/26/91

---

1. LANOXIN 0.125mgs per tablet
   One tablet daily in the morning.

2. K-TABS 10mEq per tablet
   One tablet twice a day with breakfast and supper.

3. TAGAMET 300mgs per tablet
   One tablet four times a day with meals and at bedtime.
   DO NOT DRIVE IF DROWSY WHILE TAKING.

4. LASIX 40mgs per tablet
   Three tablets with breakfast, two tablets with lunch, and two tablets with supper.

5. ISORDIL ORAL TABLETS 10mgs per tablet
   One daily at bedtime, two at 3 AM.

6. ISORDIL SL 10mgs per tablet
   One tablet under the tongue three times a day before meals.

7. CALAN 80mgs per tablet
   One tablet every 8 hours at 8 AM, 1 PM, and bedtime.

8. ZYLOPRIM 100mgs per tablet
   One tablet daily in the morning.

9. NITROBID PASTE
   Apply two inches to anterior chest four times a day before meals and at bedtime.

10. NITROSTAT 1/100th of a grain per tablet
    Place one tablet under the tongue as needed and as directed for chest pain.

11. BENTYL 20mgs per tablet
    One tablet four times a day before meals and at bedtime.
    DO NOT DRIVE IF DROWSY WHILE TAKING.

12. TALWIN 50mgs per tablet
    One tablet every 6 hours as needed for pain.
    DO NOT DRIVE IF DROWSY WHILE TKAING.

13. VALIUM 5mgs per tablet
    One-half tablet four times a day with emals and at bedtme. as needed.
    DO NOT DRIVE IF DROWSY WHILE TAKING

14. DALMANE 10mgs per capsule
    One capsule daily at bedtime as needed.
    DO NOT DRIVE IF DROWSY WHILE TAKING.

15. GAVISCON CHEWABLE TABLETS
Two tablets four times a day after meals and at bedtime.

16. MILK OF MAGNESIA
One ounce at bedtime daily.

17. METAMUCIL
One teaspoonful in a glass of water at night.

18. ECOTRIN
Two tablets twice a day after breakfast and supper.

19. STRESS TABS 600
One tablet daily after breakfast.

20. DRAMAMINE 50mgs per tablet
One tablet every 6 hours as needed for nausea.
DO NOT DRIVE IF DROWSY WHILE TAKING.

21. PROVENTIL INHALER
Two puffs four times a day before meals and at bedtime.

22. VANCERIL INHALER
Two puffs four times a day before meals and at bedtme.

23. PERICOLACE
Two tablets daily at bedtime or as directed.

24. ANTIVERT 25mgs per tablet
One tablet four times a day with meals and at bedtime.

25. CAPOTEN 12.5mgs per tablet
One tablet four times a day with emals and at bedtime.

26. CECLOR 250mgs per capsule
One capsule four times a day after meals and at bedtime.

27. PREDNISONE 5mgs per tablet
One tablet after breakfast and one tablet after supper.

28. ROBITUSSEN DM
Two teaspoonfuls four times a day after meals and at bedtime.

03/15/92
20:32

Wellby Super Drug #517

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Prescription Profile for: GEORGE ROY
31 OARTMOUTH ST
NSC**
BIOOEFORO ME 04005

Birthdate: 02/22/1921
Cust Id#: 284-5368

From 01/01/91 To 12/31/91

Rx#	Type	Date	Doctor	Quantity	Drug	Price	Copay	R.Ph
306633	R	5/05/91	ARTHUR SCOTT	100.0	LANOXIN 0.125MG TAB	6.81		EM
319291	R	5/10/91	ARTHUR SCOTT	100.0	LOPRESSOR 50MG TAB	34.79		PC
320878	R	1/26/91	ARTHUR SCOTT	100.0	NITROBIO PL 6.5MG CR CA	24.84		TB
320878	R	2/22/91	ARTHUR SCOTT	100.0	NITROBIO PL 6.5MG CR CA	26.33		CR
321735	R	2/08/91	ARTHUR SCOTT	200.0	CARDIOQUIN TAB	134.31		CR
321735	R	3/16/91	ARTHUR SCOTT	200.0	CARDIOQUIN TAB	134.31		TB
323006	R	2/08/91	ARTHUR SCOTT	100.0	CAROIZEM 30MG TAB	29.22		CR
323006	R	3/08/91	ARTHUR SCOTT	100.0	CAROIZEM 30MG TAB	29.22		EM
345582	O	3/16/91	ARTHUR SCOTT	100.0	NITROBIO PL 6.5MG CR CA	26.33		TB
345582	R	4/15/91	ARTHUR SCOTT	100.0	NITROBIO PL 6.5MG CR CA	26.33		CRC
345582	R	5/10/91	ARTHUR SCOTT	100.0	NITROBIO PL 6.5MG CR CA	26.33		PC
345582	R	6/05/91	ARTHUR SCOTT	100.0	NITROBIO PL 6.5MG CR CA	26.33		EM
3455B2	R	7/01/91	ARTHUR SCOTT	100.0	NITROBID PL 6.5MG CR CA	26.33		TB
3455B2	R	7/26/91	ARTHUR SCOTT	100.0	NITROBIO PL 6.5MG CR CA	26.33		WM
3455B2	R	8/21/91	ARTHUR SCOTT	100.0	NITROBIO PL 6.5MG CR CA	26.33		EM
347852	O	3/31/91	ARTHUR SCOTT	100.0	CAROIZEM 30MG TAB	31.07		CR
347852	R	4/28/91	ARTHUR SCOTT	100.0	CAROIZEM 30MG TAB	31.07		CR
347852	R	5/24/91	ARTHUR SCOTT	100.0	CAROIZEM 30MG TAB	31.07		EM
347852	R	6/16/91	ARTHUR SCOTT	100.0	CARDIZEM 30MG TAB	31.07		EM
347852	R	7/14/91	ARTHUR SCOTT	100.0	CAROIZEM 30MG TAB	31.07		EMC
347852	R	8/07/91	ARTHUR SCOTT	100.0	CARDIZEM 30MG TAB	33.02		RL
35108B	O	4/20/91	ARTHUR SCOTT	200.0	CARDIOQUIN TAB	153.64		TB
35108B	R	5/24/91	ARTHUR SCOTT	200.0	CAROIOQUIN TAB	153.64		EM
35108B	R	7/01/91	ARTHUR SCOTT	200.0	CARDIOQUIN TAB	153.64		TB
35108B	R	8/03/91	ARTHUR SCOTT	200.0	CAROIOQUIN TAB	153.64		RL
369263	O	8/28/91	ARTHUR SCOTT	100.0	LANOXIN 0.125MG TAB	6.81		RL
369263	R	12/16/91	ARTHUR SCOTT	100.0	LANOXIN 0.125MG TAB	6.81		MP
370438	O	9/06/91	ARTHUR SCOTT	100.0	CAROIZEM 30MG TAB	33.02		RL
370438	R	9/29/91	ARTHUR SCOTT	100.0	CAROIZEM 30MG TAB	26.66		BLC
370438	R	10/25/91	ARTHUR SCOTT	100.0	CAROIZEM 30MG TAB	26.66		OS
37043B	R	11/22/91	ARTHUR SCOTT	100.0	CAROIZEM 30MG TAB	26.66		BOL
370438	R	12/16/91	ARTHUR SCOTT	100.0	CAROIZEM 30MG TAB	33.02		MP
370743	O	9/09/91	ARTHUR SCOTT	200.0	CAROIOQUIN TAB	165.93		RL
370743	R	10/11/91	ARTHUR SCOTT	200.0	CARDIOQUIN TAB	165.93		EM
370743	R	11/19/91	ARTHUR SCOTT	200.0	CAROIOQUIN TAB	165.93		EM
370743	R	12/24/91	ARTHUR SCOTT	200.0	CARDIOQUIN TAB	165.93		RL
371927	O	9/17/91	ARTHUR SCOTT	100.0	NITROBID PL 6.5MG CR CA	27.41		RL
371927	R	10/11/91	ARTHUR SCOTT	100.0	NITROBID PL 6.5MG CR CA	27.41		EM
371927	R	11/08/91	ARTHUR SCOTT	100.0	NITROBIO PL 6.5MG CR CA	27.41		BOL
383642	O	12/04/91	ARTHUR SCOTT	100.0	NITROGLYCER 6.5MG TD CA	11.13		WM
383642	R	12/31/91	ARTHUR SCOTT	100.0	NITROGLYCER 6.5MG TO CA	11.13		MP
387612	O	12/28/91	ARTHUR SCOTT	100.0	NITROSTAT 0.3MG SL TAB	5.29		EM

						2340.21		
						========		

Type: O=original I=insurance
R=refill C=A/R charge

Pharmacist Signature: _____

Wellby Super Drug #517
335 Alfred St

OEA#:

03/15/92 Wellby Super Drug #517 Page: 1
20:33

Prescription Profile for: THERESA ROY
31 DARTMOUTH ST Birthdate: 05/25/1924
MSC COVER Cust Id#: 284-5368
BIDDEFORD ME 04005

From 01/01/91 To 12/31/91

Rx#	Type	Date	Doctor	Quantity	Drug	Price	Copay	R.Ph
308611	R	1/02/91	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	23.28		EM
308611	R	2/23/91	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	25.67		TB
308611	R	4/20/91	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	25.67		TB
308611	R	6/16/91	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	28.22		EM
308612	R	1/23/91	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	53.09		CR
308612	R	2/23/91	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	53.09		TB
308612	R	3/23/91	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	54.96		CR
308612	R	4/20/91	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	54.96		TB
308612	R	6/01/91	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	54.96		EM
308612	R	6/24/91	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	54.96		RL
308612	R	7/18/91	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	54.96		EM
308613	R	4/28/91	ARTHUR SCOTT	100.0	ZYLOPRIM 100MG TAB	16.83		CR
310083	R	6/21/91	ARTHUR SCOTT	100.0	NITROSTAT 0.6MG SL TAB	5.29		CR
310084	R	1/02/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	40.67		EM
310084	R	2/03/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	40.67		CRC
310084	R	3/08/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	43.15		EM
310084	R	4/05/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	43.15		WM
310084	R	4/28/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	43.15		CR
310084	R	6/09/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	43.15		CR
310084	R	7/02/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	43.15		RL
310084	R	7/30/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	43.15		RL
312775	R	3/08/91	ARTHUR SCOTT	100.0	LAMOXIN 0.125MG TAB	6.81		EM
312775	R	7/18/91	ARTHUR SCOTT	100.0	LAMOXIN 0.125MG TAB	6.81		EM
316667	R	1/26/91	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	45.66		TB
316667	R	3/08/91	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	45.66		EM
316667	R	3/31/91	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	50.31		CR
316667	R	4/28/91	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	50.31		CR
316667	R	6/10/91	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	50.31		RL
316667	R	7/02/91	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	50.31		RL
316667	R	7/26/91	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	50.31		WM
316667	R	8/24/91	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	50.31		RLK
325497	R	1/23/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	19.71		CR
325497	R	2/03/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	19.71		CRC
328344	R	2/08/91	ARTHUR SCOTT	120.0	NITROBID 2 OIM	17.32		CR
328344	R	3/16/91	ARTHUR SCOTT	120.0	NITROBID 2 OIM	17.32		TB
328344	R	4/11/91	ARTHUR SCOTT	120.0	NITROBID 2 OIM	17.32		TB
328344	R	6/09/91	ARTHUR SCOTT	120.0	NITROBID 2 OIM	17.32		CR
333244	R	1/11/91	ARTHUR SCOTT	180.0	AMBEMYL SYP	28.18		EM
333577	O	1/03/91	ARTHUR SCOTT	28.0	CECLOR 250MG CAP	46.57		EM
333577	R	1/11/91	ARTHUR SCOTT	28.0	CECLOR 250MG CAP	46.57		EM
333577	R	1/14/91	ARTHUR SCOTT	28.0	CECLOR 250MG CAP	46.57		TBJ
335455	O	1/14/91	ARTHUR SCOTT	30.0	PREDNISONE 5MG TAB-UPJO	3.87		TB
335455	R	1/23/91	ARTHUR SCOTT	30.0	PREDNISONE 5MG TAB-UPJO	3.87		CR
336916	O	1/23/91	ARTHUR SCOTT	21.0	CECLOR 250MG CAP	34.92		CR
339762	O	2/08/91	ARTHUR SCOTT	100.0	ISORDIL 10MG TAB	21.71		CR

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Prescription Profile for: THERESA ROY
31 DARTMOUTH ST Birthdate: 05/25/1924
MSC COVER Cust Id#: 2B4-536B
BIDDEFORD ME 04005

From 01/01/91 To 12/31/91

Rx#	Type	Date	Doctor	Quantity	Drug	Price	Copay	R.Ph
339762	R	2/17/91	ARTHUR SCOTT	100.0	ISOROIL 10MG TAB	21.71		CR
339762	R	4/16/91	ARTHUR SCOTT	100.0	ISOROIL 10MG TAB	21.71		TB
339762	R	6/01/91	ARTHUR SCOTT	100.0	ISORDIL 10MG TAB	23.86		EM
339762	R	7/11/91	ARTHUR SCOTT	100.0	ISORDIL 10MG TAB	23.86		JTE
339763	O	2/08/91	ARTHUR SCOTT	100.0	CALAN 80MG TAB	33.04		CR
339763	R	4/12/91	ARTHUR SCOTT	100.0	CALAN 80MG TAB	33.04		EM
339763	R	5/29/91	ARTHUR SCOTT	100.0	CALAN 80MG TAB	33.04		JTC
339763	R	6/28/91	ARTHUR SCOTT	100.0	CALAN 80MG TAB	33.04		CR
339763	R	7/30/91	ARTHUR SCOTT	100.0	CALAN 80MG TAB	33.04		RL
339763	R	9/06/91	ARTHUR SCOTT	100.0	CALAN 80MG TAB	33.04		WM
341111	O	2/16/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	19.71		CR
341111	R	3/08/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	19.71		EM
341111	R	3/23/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	19.71		CR
341111	R	4/05/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	19.71		WM
341111	R	4/20/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		TB
341111	R	5/14/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		RL
341163	O	2/17/91	ARTHUR SCOTT	30.0	PREDNISONE 5MG TAB-UPJO	4.14		CR
341927	O	2/22/91	ARTHUR SCOTT	100.0	ISOROIL 10MG SL TABS	21.71		CR
341927	R	3/31/91	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	21.71		CR
341927	R	5/14/91	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	23.76		RL
341927	R	6/21/91	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	23.76		CR
341927	R	7/26/91	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	23.76		WM
341927	R	8/24/91	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	23.76		RLK
341927	R	10/07/91	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	23.76		MP
341927	R	11/08/91	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	23.76		BOL
341927	R	12/12/91	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	23.76		DS
34192B	O	2/22/91	ARTHUR SCOTT	100.0	DALMANE 30MG CAP	51.83		CR
346765	O	3/23/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	22.84		CR
346765	R	3/31/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	22.84		CR
346765	R	4/16/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	23.86		TB
346765	R	4/28/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	23.86		CR
346765	R	5/29/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	25.38		JTC
346765	R	6/05/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	25.38		EM
346765	R	6/14/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	25.38		CR
346765	R	6/21/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	25.38		CR
346765	R	7/02/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	25.38		RL
346765	R	7/11/91	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	40.46		JTE
346765	R	7/26/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	25.38		WM
346765	R	7/30/91	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	40.46		RL
346765	R	8/21/91	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	41.51		EM
346765	R	9/06/91	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	41.51		WM
346765	R	9/28/91	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	41.51		RL
346765	R	10/19/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	20.76		EM
346765	R	10/29/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	20.76		RL
346765	R	11/12/91	ARTHUR SCOTT	50.0	CAPOTEN 12.5MG TAB	20.76		RLC

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Prescription Profile for: THERESA ROY
31 DARTMOUTH ST Birthdate: 05/25/1924
MSC COVER Cust Id#: 284-5368
BIDDEFORD ME 04005
From 01/01/91 To 12/31/91

Rx#	Type	Date	Doctor	Quantity	Drug	Price	Copay	R.Ph
346765	R	11/19/91	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	41.51		OPB
346765	R	12/04/91	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	41.51		WM
349500	O	4/10/91	ARTHUR SCOTT	20.0	CIPRO 500MG TAB	50.43		CRJ
351089	D	4/20/91	ARTHUR SCOTT	28.0	CECLOR 250MG CAP	46.57		TB
351089	R	4/28/91	ARTHUR SCOTT	28.0	CECLOR 250MG CAP	46.57		CR
351089	R	5/14/91	ARTHUR SCOTT	28.0	CECLOR 250MG CAP	46.57		RL
354065	O	5/10/91	ARTHUR SCOTT	100.0	PREDNISONE 5MG TAB-UPJO	4.14		EM
355615	O	5/21/91	ARTHUR SCOTT	40.0	FLAGYL 250MG TAB	45.99		JT
356486	O	5/29/91	ARTHUR SCOTT	20.0	FLAGYL 250MG TAB	23.00		JTC
357107	O	6/03/91	ARTHUR SCOTT	60.0	MYCOSTATIN ORAL SUS	25.46		RL
357107	R	6/24/91	ARTHUR SCOTT	60.0	MYCOSTATIN ORAL SUS	25.46		RL
357547	O	6/05/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		EM
357547	R	6/14/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		CR
357547	R	6/24/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		RL
357547	R	7/02/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		RL
357547	R	7/14/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		EMC
357547	R	7/26/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		WM
357547	R	8/03/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		RL
357547	R	8/16/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		BDL
357547	R	8/24/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		RLK
357547	R	9/06/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		WM
357547	R	9/19/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		WM
357547	R	9/28/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		RL
357547	R	10/11/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		EM
357547	R	10/22/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		EM
357547	R	11/08/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		BOL
357547	R	11/19/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		OPB
357547	R	11/30/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		EM
357547	R	12/12/91	ARTHUR SCOTT	100.0	LASIX 40MG TAB	22.41		OS
360796	O	6/28/91	ARTHUR SCOTT	100.0	DALMANE 30MG CAP	51.83		CR
365926	O	8/03/91	ARTHUR SCOTT	10.0	CIPRO 500MG TAB	25.21		RL
365927	O	8/03/91	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	28.22		RL
365927	R	9/28/91	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	28.22		RL
365927	R	11/22/91	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	28.22		BDL
366427	O	8/07/91	ARTHUR SCOTT	60.0	NITRODID 2 OIM	8.66		RL
366427	R	8/24/91	ARTHUR SCOTT	60.0	NITRODID 2 OIM	8.66		RLK
366427	R	9/19/91	ARTHUR SCOTT	60.0	NITRODIO 2 OIM	8.66		WM
366427	R	10/09/91	ARTHUR SCOTT	60.0	NITRODID 2 OIM	8.66		MP
366427	R	10/31/91	ARTHUR SCOTT	60.0	NITRODID 2 OIM	8.66		OS
366427	R	11/22/91	ARTHUR SCOTT	60.0	NITRODIO 2 OIM	8.66		BOL
366427	R	12/16/91	ARTHUR SCOTT	60.0	NITRODIO 2 OIM	8.66		MP
367233	O	8/13/91	ARTHUR SCOTT	100.0	ZYLOPRIM 100MG TAB	16.83		EM
367233	R	11/22/91	ARTHUR SCOTT	100.0	ZYLOPRIM 100MG TAB	16.83		BOL
367234	O	8/13/91	ARTHUR SCOTT	100.0	ISORDIL 10MG TAB	23.86		RL
367234	R	9/14/91	ARTHUR SCOTT	100.0	ISORDIL 10MG TAB	23.86		RLK

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Prescription Profile for: THERESA ROY
31 DARTMOUTH ST Birthdate: 05/25/1924
MSC COVER Cust Id#: 284-5368
BIDDEFORD ME 04005

From 01/01/91 To 12/31/91

Rx#	Type	Date	Doctor	Quantity	Drug	Price	Copay	R.Ph
367234	R	10/16/91	ARTHUR SCOTT	100.0	ISOROIL 10MG TAB	23.86		RL
367234	R	11/22/91	ARTHUR SCOTT	100.0	ISOROIL 10MG TAB	23.86		BOL
367691	O	8/16/91	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	54.96		BOL
367691	R	9/10/91	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	54.96		RL
367691	R	10/07/91	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	54.96		MP
367691	R	11/08/91	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	54.96		BOL
367691	R	11/30/91	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	54.96		EM
369119	O	8/27/91	OWEN OOW	15.0	ACETAMINOPHEN/COD 3 300	4.14		BOL
369264	O	8/28/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	43.15		RL
369264	R	9/28/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	44.90		RL
369264	R	10/29/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	44.90		RL
369264	R	11/19/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	44.90		OPB
369264	R	12/28/91	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	44.90		EM
372696	O	9/23/91	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	52.82		WM
372696	R	10/19/91	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	52.82		EM
372696	R	11/15/91	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	52.82		EM
372696	R	12/12/91	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	52.82		OS
374835	O	10/07/91	ARTHUR SCOTT	100.0	DALMANE 30MG CAP	55.93		MP
375543	O	10/11/91	ARTHUR SCOTT	100.0	LANOXIN 0.125MG TAB	6.81		EM
375548	O	10/11/91	ARTHUR SCOTT	100.0	CALAN 80MG TAB	33.04		MP
375548	R	11/15/91	ARTHUR SCOTT	100.0	CALAN 80MG TAB	33.04		EM
375548	R	12/28/91	ARTHUR SCOTT	100.0	CALAN 80MG TAB	32.92		EM
376198	O	10/16/91	ARTHUR SCOTT	20.0	CIPRO 500MG TAB	50.43		RL
376198	R	10/25/91	ARTHUR SCOTT	20.0	CIPRO 500MG TAB	50.43		OS
379450	O	11/06/91	ARTHUR SCOTT	20.0	CIPRO 500MG TAB	50.43		WM
379450	R	11/19/91	ARTHUR SCOTT	20.0	CIPRO 500MG TAB	50.43		DPB
385649	O	12/17/91	ARTHUR SCOTT	28.0	CECLOR 250MG CAP	51.22		RL

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Type: O=original I=insurance
R=refill C=A/R charge

Pharmacist Signature: James Collins

Wellby Super Drug #517 OEA#:
335 Alfred St
Biddeford ME 04005

03/13/91 Wellby Super Drug #517 Page: 1
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Prescription Profile for: THERESA ROY
31 DARTMOUTH ST Birthdate: 05/25/1924
MSC COVER Cust Id#: 284-5368
BIDDEFORD ME 04005
From 01/01/90 To 12/31/90

Rx#	Type	Date	Doctor	Quantity	Drug	Price	Copay	R.Ph
250679	R	1/20/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	32.86		EM
250679	R	2/17/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	32.86		EM
250679	R	3/15/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	32.86		EM
250679	R	4/11/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	32.86		JH
250679	R	5/04/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	35.03		TB
250679	R	5/31/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	35.03		SS
250679	R	6/24/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	35.03		SS
250983	R	3/23/90	ARTHUR SCOTT	100.0	ZYLOPRIM 100MG TAB	10.71		WM
250983	R	6/15/90	ARTHUR SCOTT	100.0	ZYLOPRIM 100MG TAB	10.71		EM
250984	R	1/07/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	46.80		EM
250984	R	2/05/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	46.80		TB
250984	R	3/02/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	46.80		SS
250984	R	3/30/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	46.80		SS
250984	R	4/25/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	46.80		SS
250984	R	5/23/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	46.80		SS
250984	R	6/15/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	52.50		EM
254936	R	2/17/90	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	19.29		EM
254936	R	4/13/90	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	19.29		TB
254936	R	5/31/90	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	20.66		SS
272158	RI	1/20/90	ARTHUR SCOTT	200.0	LASIX 40MG TAB	32.35	2.00	EM
272158	RI	3/02/90	ARTHUR SCOTT	200.0	LASIX 40MG TAB	32.35	2.00	SS
272158	RI	4/04/90	ARTHUR SCOTT	208.0	LASIX 40MG TAB	32.35	2.00	TB
272158	RI	5/09/90	ARTHUR SCOTT	200.0	LASIX 40MG TAB	32.35	2.00	PC
272159	RI	2/02/90	ARTHUR SCOTT	100.0	ISOROIL 10MG SL TABS	21.45	2.00	TB
272159	RI	3/15/90	ARTHUR SCOTT	100.0	ISOROIL 10MG SL TABS	21.45	2.00	EM
272159	RI	4/20/90	ARTHUR SCOTT	100.0	ISOROIL 10MG SL TABS	21.45	2.00	EM
272160	RI	2/21/90	ARTHUR SCOTT	120.0	INDERAL 10MG TAB	17.49	2.00	SS
272160	RI	3/30/90	ARTHUR SCOTT	120.0	INDERAL 10MG TAB	17.49	2.00	SS
272160	RI	4/27/90	ARTHUR SCOTT	120.0	INDERAL 10MG TAB	19.27	2.00	PC
272162	RI	1/13/90	ARTHUR SCOTT	100.0	ISOROIL 10MG TAB	20.11	2.00	EM
272162	RI	2/17/90	ARTHUR SCOTT	100.0	ISOROIL 10MG TAB	21.45	2.00	EM
272162	RI	3/25/90	ARTHUR SCOTT	100.0	ISOROIL 10MG TAB	21.45	2.00	TB
272162	RI	4/27/90	ARTHUR SCOTT	100.0	ISOROIL 10MG TAB	21.45	2.00	PC
272734	RI	1/04/90	ARTHUR SCOTT	60.0	NITROBID 2 OIN	9.15	2.00	WM
272734	RI	1/20/90	ARTHUR SCOTT	60.0	NITROBID 2 OIN	9.15	2.00	EM
272734	RI	2/17/90	ARTHUR SCOTT	60.0	NITROBID 2 OIN	9.15	2.00	EM
272734	RI	3/09/90	ARTHUR SCOTT	60.0	NITROBID 2 OIN	9.15	2.00	TB
272734	RI	3/27/90	ARTHUR SCOTT	60.0	NITROBID 2 OIN	9.15	2.00	SS
272734	RI	4/15/90	ARTHUR SCOTT	60.0	NITROBID 2 OIN	9.15	2.00	EM
276607	RI	1/20/90	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	38.69	2.00	EM
276607	RI	2/11/90	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	38.69	2.00	SS
276607	RI	3/02/90	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	38.69	2.00	SS
276607	RI	3/25/90	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	38.69	2.00	TB
276607	RI	4/11/90	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	38.69	2.00	JH
277858	RI	2/05/90	ARTHUR SCOTT	100.0	CALAN 80MG TAB	28.60	2.00	TB

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03/13/91 Wellby Super Drug 0517 Page: 2
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Prescription Profile for: THERESA ROY
31 DARTMOUTH ST Birthdate: 05/25/1924
MSC COVER Cust Id#: 284-5368
BIDDEFORD ME 04005
From 01/01/90 To 12/31/90

Rx#	Type	Date	Doctor	Quantity	Drug	Price	Copay	R.Ph	
277858	RI	3/15/90	ARTHUR SCOTT	100.0	CALAN 80MG TAB	32.21	2.00	EM	3021
277858	RI	4/20/90	ARTHUR SCOTT	100.0	CALAN 80MG TAB	32.21	2.00	EM	3021
277858	RI	5/23/90	ARTHUR SCOTT	100.0	CALAN 80MG TAB	32.21	2.00	SS	3021
277858	RI	6/24/90	ARTHUR SCOTT	100.0	CALAN 80MG TAB	32.21	2.00	SS	3021
279076	O	1/05/90	ARTHUR SCOTT	30.0	CIPRO 250MG TAB	57.42		SS	
279076	R	1/18/90	ARTHUR SCOTT	30.0	CIPRO 250MG TAB	57.42		EM	
280429	OI	1/13/90	ARTHUR SCOTT	100.0	LANOXIN 0.125MG TAB	5.98	2.00	EM	398
280429	RI	4/25/90	ARTHUR SCOTT	100.0	LANOXIN 0.125MG TAB	5.98	2.00	SS	398
284484	O	2/07/90	ARTHUR SCOTT	100.0	DALMANE 30MG CAP	32.49		EM	
284486	O	2/07/90	ARTHUR SCOTT	30.0	CIPRO 250MG TAB	62.56		EM	
284486	R	2/21/90	ARTHUR SCOTT	30.0	CIPRO 250MG TAB	62.56		SS	
284486	R	3/23/90	ARTHUR SCOTT	30.0	CIPRO 250MG TAB	62.56		WM	
284486	R	4/13/90	ARTHUR SCOTT	30.0	CIPRO 250MG TAB	61.11		TB	222
291535	OI	3/27/90	ARTHUR SCOTT	100.0	NITROSTAT 0.6MG SL TAB	4.22	2.00	SS	
296353	O	4/27/90	ARTHUR SCOTT	28.0	ERY-TAB 250MG TAB	4.12		PC	
296353	R	5/04/90	ARTHUR SCOTT	28.0	ERY-TAB 250MG TAB	4.12		TB	
296353	R	5/09/90	ARTHUR SCOTT	28.0	ERY-TAB 250MG TAB	4.12		PC	
296354	O	4/27/90	ARTHUR SCOTT	180.0	AMBENYL SYP	18.80		PC	X
296782	OI	5/01/90	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	42.18	2.00	TB	4018
296782	RI	5/23/90	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	42.18	2.00	SS	4018
296782	RI	6/12/90	ARTHUR SCOTT	100.0	CAPOTEN 12.5MG TAB	42.18	2.00	LDK	4018
297692	OI	5/07/90	ARTHUR SCOTT	60.0	NITROBID 2 OIN	8.93	2.00	TB	693
297692	RI	5/27/90	ARTHUR SCOTT	60.0	NITROBID 2 OIN	8.93	2.00	EM	693
297692	RI	6/22/90	ARTHUR SCOTT.	60.0	NITROBID 2 OIN	9.17	2.00	EM	717
300462	OI	5/25/90	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	21.45	2.00	SS	1945
301275	OI	5/31/90	ARTHUR SCOTT	100.0	ISORDIL 10MG TAB	21.45	2.00	SS	1945
301278	OI	5/31/90	ARTHUR SCOTT	120.0	INDERAL 10MG TAB	19.27	2.00	SS	1727
301278	RI	6/30/90	ARTHUR SCOTT	120.0	INDERAL 10MG TAB	19.27	2.00	TB	1727
303164	OI	6/12/90	ARTHUR SCOTT	200.0	LASIX 40MG TAB	32.35	2.00	LDK	3035
305522	O	6/28/90	ARTHUR SCOTT	100.0	DALMANE 30MG CAP	28.88		TB	X
308610	O	7/21/90	ARTHUR SCOTT	100.0	ANTIVERT 12.5MG TAB	31.20		SS	X
308610	R	8/13/90	ARTHUR SCOTT	100.0	ANTIVERT 12.5MG TAB	31.71		TB	
308610	R	9/08/90	ARTHUR SCOTT	100.0	ANTIVERT 12.5MG TAB	31.71		EM	
308611	O	7/21/90	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	22.50		SS	
308611	R	9/28/90	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	23.28		SS	
308611	R	11/16/90	ARTHUR SCOTT	100.0	K-TABS 10MEQ CR TAB	23.28		EM	
308612	O	7/21/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	52.50		SS	
308612	R	8/20/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	53.18		SS	
308612	R	9/08/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	53.18		EM	
308612	R	10/10/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	53.18		PC	
308612	R	11/04/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	53.18		SS	
308612	R	12/02/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	53.18		EM	
308612	R	12/29/90	ARTHUR SCOTT	100.0	TAGAMET 300MG TAB	47.67		EM	
308613	O	7/21/90	ARTHUR SCOTT	100.0	ZYLOPRIM 100MG TAB	10.71		SS	
308613	R	12/29/90	ARTHUR SCOTT	100.0	ZYLOPRIM 100MG TAB	15.57		EM	

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03/13/91 Wellby Super Drug #517 Page: 3
08:15
Prescription Profile for: THERESA ROY
3I DARTMOUTH ST Birthdate: 05/25/1924
MSC COVER Cust Id#: 284-5368
BIDDEFORD ME 04005
From 01/01/90 To 12/31/90

Rx#	Type	Date	Doctor	Quantity	Drug	Price	Copay	R.Ph
308614	OI	7/21/90	ARTHUR SCOTT	60.0	NITROBID 2 OINT	9.17	2.00	SS
308614	RI	8/20/90	ARTHUR SCOTT	60.0	NITROBID 2 OINT	9.17	2.00	SS
308614	RI	9/17/90	ARTHUR SCOTT	60.0	NITROBID 2 OINT	9.17	2.00	SS
308614	RI	10/13/90	ARTHUR SCOTT	60.0	NITROBID 2 OINT	9.17	2.00	SS
308614	RI	10/31/90	ARTHUR SCOTT	60.0	NITROBID 2 OINT	9.17	2.00	SS
308614	RI	11/16/90	ARTHUR SCOTT	60.0	NITROBID 2 OINT	8.88	2.00	EM
308615	OI	7/21/90	ARTHUR SCOTT	100.0	ISORDIL 10MG TAB	23.15	2.00	SS
308615	RI	8/20/90	ARTHUR SCOTT	100.0	ISORDIL 10MG TAB	23.15	2.00	SS
308615	RI	9/22/90	ARTHUR SCOTT	100.0	ISORDIL 10MG TAB	23.15	2.00	SS
308615	RI	10/27/90	ARTHUR SCOTT	100.0	ISORDIL 10MG TAB	23.15	2.00	TB
308615	RI	11/30/90	ARTHUR SCOTT	100.0	ISORDIL 10MG TAB	22.16	2.00	TB
308615	RI	12/29/90	ARTHUR SCOTT	100.0	ISORDIL 10MG TAB	22.16	2.00	EM
308616	OI	7/21/90	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	23.15	2.00	SS
308616	RI	8/20/90	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	23.15	2.00	SS
308616	RI	10/03/90	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	23.15	2.00	TB
308616	RI	11/04/90	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	23.15	2.00	SS
308616	RI	11/30/90	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	22.16	2.00	TB
308616	RI	12/29/90	ARTHUR SCOTT	100.0	ISORDIL 10MG SL TABS	22.16	2.00	EM
309658	OI	7/29/90	ARTHUR SCOTT	100.0	LASIX 40MG TAB	17.85	2.00	EM
309658	RI	8/13/90	ARTHUR SCOTT	100.0	LASIX 40MG TAB	17.85	2.00	TB
30965B	RI	9/04/90	ARTHUR SCOTT	100.0	LASIX 40MG TAB	17.85	2.00	SS
309658	RI	9/24/90	ARTHUR SCOTT	100.0	LASIX 40MG TAB	17.85	2.00	EM
309658	RI	10/10/90	ARTHUR SCOTT	100.0	LASIX 40MG TAB	17.85	2.00	PC
309658	RI	10/27/90	ARTHUR SCOTT	100.0	LASIX 40MG TAB	17.85	2.00	TB
310083	OI	8/01/90	ARTHUR SCOTT	100.0	NITROSTAT 0.6MG SL TAB	4.22	2.00	SS
310083	RI	11/30/90	ARTHUR SCOTT	100.0	NITROSTAT 0.6MG SL TAB	4.92	2.00	TB
310084	O	8/01/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	37.81		SS
310084	R	8/28/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	38.58		EM
310084	R	9/22/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	38.58		SS
310084	R	10/19/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	40.67		TB
310084	R	11/16/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	40.67		EM
310084	R	12/11/90	ARTHUR SCOTT	100.0	BENTYL 20MG TAB	40.67		TB
311480	OI	8/10/90	ARTHUR SCOTT	100.0	CALAN 80MG TAB	32.62	2.00	SS
311480	RI	9/08/90	ARTHUR SCOTT	100.0	CALAN 80MG TAB	32.62	2.00	EM
311480	RI	10/19/90	ARTHUR SCOTT	100.0	CALAN 80MG TAB	32.62	2.00	TB
311480	RI	11/23/90	ARTHUR SCOTT	100.0	CALAN 80MG TAB	32.62	2.00	TB
311480	RI	11/30/90	ARTHUR SCOTT	100.0	CALAN 80MG TAB	32.62	2.00	TB
311480	RI	12/29/90	ARTHUR SCOTT	100.0	CALAN 80MG TAB	32.62	2.00	EM
312775	OI	8/20/90	ARTHUR SCOTT	100.0	LANOXIN 0.125MG TAB	6.07	2.00	SS
312775	RI	11/30/90	ARTHUR SCOTT	100.0	LANOXIN 0.125MG TAB	7.56	2.00	TB
316667	O	9/16/90	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	45.66		TB
316667	R	10/16/90	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	45.66		TB
316667	R	11/13/90	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	45.66		SS
316667	R	12/02/90	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	45.66		EM
316667	R	12/29/90	ARTHUR SCOTT	100.0	ANTIVERT 25MG TAB	45.66		EM

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03/13/91 Wellby Super Drug #517 Page: 4
08:15

Prescription Profile for: THERESA ROY
31 DARTMOUTH ST Birthdate: 05/25/1924
MSC COVER Cust Id#: 284-5368
BIDDEFORD ME 04005

From 01/01/90 To 12/31/90

Rx#	Type	Date	Doctor	Quantity	Drug	Price	Copay	R.Ph
316668	O	9/16/90	ARTHUR SCOTT	100.0	VALIUM 5MG TAB	43.33		TB
316669	O	9/16/90	ARTHUR SCOTT	50.0	DALMANE 30MG CAP	17.92		TB
321736	O	10/19/90	ARTHUR SCOTT	20.0	CIPRO 250MG TAB	47.74		TB
321737	O	10/19/90	ARTHUR SCOTT	180.0	AMBENYL SYP	28.18		TB
321737	R	10/28/90	ARTHUR SCOTT	180.0	AMBENYL SYP	28.18		TB
321737	R	12/08/90	ARTHUR SCOTT	180.0	AMBENYL SYP	28.18		TB
323005	O	10/27/90	ARTHUR SCOTT	20.0	CIPRO 500MG TAB	47.98		TB
325235	OI	11/10/90	ARTHUR SCOTT	17.0	PROVENTIL 90MC6/AC AER	17.24	2.00	EM
325235	RI	12/02/90	ARTHUR SCOTT	17.0	PROVENTIL 90MC6/AC AER	17.24	2.00	EM
325236	O	11/10/90	ARTHUR SCOTT	15.0	CIPRO 250MG TAB	35.81		EM
325236	R	11/16/90	ARTHUR SCOTT	15.0	CIPRO 250MG TAB	38.29		EM
325497	OI	11/13/90	ARTHUR SCOTT	100.0	LASIX 40MG TAB	17.13	2.00	SS
325497	RI	11/30/90	ARTHUR SCOTT	100.0	LASIX 40MG TAB	17.13	2.00	TB
325497	RI	12/18/90	ARTHUR SCOTT	100.0	LASIX 40MG TAB	17.13	2.00	TB
325497	RI	12/29/90	ARTHUR SCOTT	100.0	LASIX 40MG TAB	17.13	2.00	EM
327164	O	11/23/90	ARTHUR SCOTT	15.0	CIPRO 250MG TAB	38.29		TB
327164	R	12/20/90	ARTHUR SCOTT	15.0	CIPRO 250MG TAB	38.29		EM
328344	OI	11/30/90	ARTHUR SCOTT	120.0	NITROBID 2 OIN	14.41	2.00	TB
328344	RI	12/29/90	ARTHUR SCOTT	120.0	NITROBID 2 OIN	14.41	2.00	EM
329102	O	12/05/90	ARTHUR SCOTT	100.0	DALMANE 30MG CAP	52.76		EM
329103	O	12/05/90	ARTHUR SCOTT	15.0	CIPRO 250MG TAB	38.29		EM
329103	R	12/11/90	ARTHUR SCOTT	15.0	CIPRO 250MG TAB	38.29		TB
329103	R	12/26/90	ARTHUR SCOTT	15.0	CIPRO 250MG TAB	35.52		CR
333244	O	12/31/90	ARTHUR SCOTT	180.0	AMBENYL SYP	28.18		CR
						4520.96	172.00	

Type: O=original I=insurance
R=refill C=A/R charge

Pharmacist Signature: [signature]
Wellby Super Drug #517
335 Alfred St
Biddeford ME 04005

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1513 1513 1513 1513 } 6052
1241 1241 2482
4- 11582

1- 56456
2- 37638
3- 57899
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104.00 Total
pres. Paid 2989.21

Senator COHEN. Thank you very much, Mr. Roy.
Mr. Graham.

STATEMENT OF WILFRED W. GRAHAM, PORTLAND, ME

Mr. GRAHAM. Senator Cohen, ladies and gentlemen, thank you for the opportunity to testify before this Special Committee on Aging. I shall try to be brief in describing the effect that the increasing cost of prescription drugs is having on my ability to run a home.

My wife and I live on a combined monthly income of $1,757.60. The sources for this income are my wife's Social Security, $420; my Social Security, $947; my pension from Key Bank, $158.85; and my pension from American Investment Company, $231.75.

Although Medicare is the primary insurance carrier for both of us, we are also covered by the following health insurance policies. My wife, who has been disabled since a stroke in 1985, has a Blue Cross policy which costs $60.75 per month. This policy has no provision for prescription reimbursement, although its cost is about to increase to $76. I have a health insurance policy through AARP for which I pay $70 monthly. This policy does have an allowance for prescription drugs. However, as long as the policy which is included in my retirement package from Key Bank is in effect, I can collect nothing through AARP for drug expenses.

Finally, as mentioned above, I have my health insurance coverage through Key Bank. This policy allows for reimbursement of 80 percent of prescription drug costs after reaching a deductible of $300. Although it may seem overly cautious to purchase insurance over and above the amount provided through my retirement package, I have tried to anticipate the reduction or erosion of benefits that seems always to plague retirees. Justification for my concerns arrived last month, when I received a memo spelling out proposed changes in my Key Bank health insurance that are to take effect in little more than 1 year.

Prescription costs for my wife and me over the last 3 years have steadily increased. In 1989 it was $750, in 1990 it was $1,012, and in 1991 it was $1,347, and in the first 3 months of this year it was over $400.

The increase in some of the drugs that we regularly use since 1989 include Reglan, up 42 percent; Tenormin, up 32 percent; Centrax, up 57 percent; and Lotrisone Cream, up 31 percent. I can only imagine what such costs will be in years to come and what part of our retirement income those costs will consume.

Despite my insurance expenses, I fully realize that I am in a much more fortunate position than many other individuals in the State of Maine and elsewhere in America. By economizing in other areas, my wife and I have thus far been able to meet the absolute necessity of health insurance coverage. However, as the cost of drugs continues to skyrocket and as the need for them increases with advancing age, we look to the future with real concern.

I definitely feel that Congress should consider drug costs as one of their most important priorities, especially for the aged. Am I being selfish when I say "especially for the aged"? I do not believe that I am. It is a foregone conclusion that more and more compa-

nies will, out of economic necessity, pass the cost of health insurance on to the employee, but the employee has the opportunity to increase his wages to offset the additional expense. The aged, who must live on fixed incomes, are the ones who will suffer.

I sincerely wish I had some constructive proposals to contribute to this Special Committee, but I'm afraid I'll have to leave that in your very capable hands, Senator Cohen. I have all the faith in the world that we can look for some relief—not welfare, please—down the road.

Many thanks for allowing me to participate.

Senator COHEN. Thank you very much, Mr. Graham.

Mrs. Zimmerman.

STATEMENT OF GERTRUDE ZIMMERMAN, BRUNSWICK, ME

Mrs. ZIMMERMAN. My name is Gertrude Zimmerman. I am a widow with three grown children, two in Maine and one in Washington. I will be 76 years old in September, and I live alone in Brunswick. I am fortunate in that I work 20 hours a week at Morse High School in Bath in a program administered by AARP called SCEP, Senior Citizen Employment Program. I am paid $4.25 an hour. My monthly take-home pay is $314.

I take two medications daily. The first, Feldene, I take once a day. The second medication is Sinumet, which is taken four times daily. I purchase both these medications locally, and my pharmacy matches AARP prices. Neither my Blue Cross nor my Medicare will pay for the medications I need. I have no other insurance; therefore, I pay for all medicines myself.

For me, both Feldene and Sinumet are necessary if I am to continue to function at my present level. Without them I would not be able to continue working. I would be having daily pain and discomfort and insomnia each night.

Feldene, which I take for osteoarthritis, has this pricing history. In March 1990, 30 Feldene, which is a month's supply for me, cost $44.55. In July 1990, it increased to $48.85. In December 1990, it went to $51.25. In October 1991, it went to $54.98. In 19 months, Feldene rose from $44.55 to $54.98, an increase of $10.43, or about 24 percent.

Sinumet, I take to control a neurological condition which causes constant leg spasms and insomnia. It has been priced as follows. In February 1990, 100 Sinumet, less than a month's supply, cost $42.25. On September 5, 1990, 100 Sinumet cost $45.95. On September 27, 1990, it rose to $48.45. In October 1990, it cost $50.25. In December 1990, it was now priced at $57.85. So from February 1990 to December 1990, a period of 10 months, Sinumet rose $15.60, or 37 percent.

At this time, December 1990, the pharmaceutical company issued Sinumet in a time-released tablet, which meant that I could go from five daily to four daily. The new time-released tablet was priced at $96.39 for 100. In December 1991, the newly marketed Sinumet tablet was now priced at $109.40. In a period of 2 months, the new Sinumet went up $13, a 14-percent rise. This is in addition to the earlier increase of 37 percent.

Each price increase in prescription medicines affect the elderly, those who purchase the most medicine. In some instances, we have had to choose between buying our necessary medicine or paying our telephone, electric, fuel, et cetera. In my case, I have gone to the measure of buying half a prescription.

Senator Cohen's bill would give great hope to me and to tens of thousands of other elderly—hope that we would not have to choose between buying medications and paying monthly bills. It would give us hope that the greedy upward spiral of pharmaceutical prices might be curbed. It would give us hope that the needs of the elderly were being recognized.

Senator COHEN. Thank you very much, Mrs. Zimmerman.

Mrs. Trumble.

STATEMENT OF LILLIAN TRUMBLE, LISBON FALLS, ME

Mrs. TRUMBLE. Thank you for letting me come here. I am Lillian Trumble from Lisbon Falls. I was trained and worked as a nurse, an RN, for 50 years, and since then I have done some nursing, but I haven't done too much of it now, because I'm not able to. We have an income from Social Security, and we get about $1,571.74 a month. We have been ill, but not serious, and yet my husband is the most serious, with emphysema. In the last year, he has been in the hospital four times for a week or 2 weeks. He needs glasses, and he needs new teeth. We just can't afford that. We found expenses very high for our teeth and for eyes, and we both wear glasses. I have worn glasses for many years, and about 10 years ago, I started seeing double again. My eyes do not work together, and I am losing some of the sight in my left eye, and I may lose all of it. I have a cataract in the other one. I've had one operation for the cataract, and it came out well. I cannot read really much of anything except with a patch over that left eye. I've had it for 3 years, and I have to take medication to be able to swallow. I have osteoporosis of my back. I've had trouble with skin cancer, and I've had glasses since I was 7 years old. I have lenses in my glasses that make them cost more in order to be able to see.

Senator COHEN. Do you have a total amount that you have to spend each month?

Mrs. TRUMBLE. We have about $200 that we spend for medicine every month, and it might be a little bit higher some months. I, too, have to buy for my medical problem I should say two or three pills a day, and they're $1 and some cents apiece, each capsule. I've been able to eat carefully, and if I cut out certain foods or cut down on them, I get along quite well without too much pain.

I have to take Imipramine, which is a medicine for depression, and that's $17. I have to take Premarin, I take vitamin capsules, I take aspirin. My husband has to take Uniphyl and a capsule by the name of Provental REP, and Prednisone, and Amoxicillin, and an Atrovent inhaler for $26, and Asmacort is $34. The Prednisone is $4. Now, these are all higher. They give us a 10 percent discount, which helps very much.

Senator COHEN. What is your total monthly income? You said you spend about $200 a month on medication?

Mrs. TRUMBLE. Yes, I spend $200——

Senator COHEN. What is your monthly income? How much money do you have coming in?

Mrs. TRUMBLE. We have $1,571.74 plus a small investment check three or four times a year. We're getting a little increase—and we appreciate it—on our Social Security this month, but it doesn't meet the rising cost of all the things that we have to spend for each month. Because we want to stay in our own home. It's a humble place, and we like it, and we can get along there very well for quite a while, I think. We haven't any assistance, and we haven't asked for it. By the way, I am nearly 80 years old, both of us are, and we're very happy that we can do what we can do, but the situation is taking our savings, and we didn't have much savings when we retired.

Senator COHEN. Mrs. Trumble, thank you very much for your testimony. You may have come the shortest distance of all the witnesses, but you came under some special circumstances. I understand your husband went to the hospital again last week——

Mrs. TRUMBLE. Yes, he was in 5 days.

Senator COHEN. Well, I'm going to ask a few questions of this panel, but I hope it's evident or I've tried to make it evident to the people who are here that what we've tried to do is present a cross section of people in our State from various income levels, those who still are working, those who have been employees and those who have retirement plans. There is no one that is safe or insulated against the ever-escalating costs of medical care or prescription drugs.

Mr. Graham has planned very well, listening to his testimony, for his retirement, and he has a retirement plan with Key Bank, and even that may be changed in the future. That may cut back because companies can no longer afford to pay these prices for those benefits.

Let me begin, Mr. Rawley, do you have any idea how much your medications have increased over the last year, the percentage basis?

Mr. RAWLEY. No, sir. Since Aileen had—she used to do all the bookkeeping, and since Aileen had the stroke, I have been doing my best with the accounts. I have no idea of the monthly increase on the cost of different medications. All I know is that my sighs get deeper as the months go by, and it is to the point now—we've had our illnesses spread out over a period of time, so with each illness, there are new bills. So we really don't have anything to compare them to. All I know is that the cost is growing.

Senator COHEN. Have you got any insurance coverage for those?

Mr. RAWLEY. We have AARP, which does have a medical—they do pay for some pills. However, their system is that they will pay 50 percent of 50 percent. In other words, if we have $100, let's say, they would pay $25. But the difficulty is that you have to wait for a long period of time before you send them in to the insurance company. Meanwhile, you have gone through $200 of medication before you even hear a whisper from AARP. This is nothing against AARP, believe me. I thank God for them.

Senator COHEN. Well, they're not the ones who provide the actual reductions as such. They are the ones who negotiate, I assume, with the drug industry so that they're going to get the

benefit by negotiating on your behalf, but they don't provide the 50 percent reduction themselves.

Mr. RAWLEY. No, we don't get a 50—we get a rebate. I'm sorry.

Senator COHEN. Okay. Let me ask you, do you qualify for the State of Maine low-cost drug program?

Mr. RAWLEY. Believe it or not, we're $1,100.

We did look into that, and we're $1,100 over.

Senator COHEN. Do you recall the cost of the beta blocker medication you have to take?

Mr. RAWLEY. Recently it's been about $32 to $35. I'd have to ask Bill about that. It seems to me it's about $35 now. It used to be, back in 1982—and this is just off the top of my head—it used to be about $18.

Senator COHEN. Have you explored with your pharmacist, who will be testifying here later, whether there are any generic alternatives of the medication that you take? For example, you mentioned that inhaler.

Mr. RAWLEY. Thankfully, he called me about 2 weeks ago and said that there was a generic replacement for them, so we now are on them, and there was quite a reduction in that. However, the reduction in that—for instance, Aileen's medication that she takes, $80-some-odd, that has jumped, and that's a month, so you gain on one hand and you lose on another.

Senator COHEN. Mr. Roy, I want to ask you a few questions. As part of your testimony that you submitted prior to the hearing, you included a medication list from your wife's doctor and it lists all the medications she has to take daily. The list I'll include as part of the record, but you mentioned she takes how many on a daily basis?

Mr. ROY. Forty-eight.

Senator COHEN. She has to take 48 medications a day?

Mr. ROY. Yes.

Senator COHEN. How long will she have to continue to take these medications?

Mr. ROY. It's permanent.

Senator COHEN. I won't ask how old your wife is because I don't want to get myself in trouble, but I assume she still has quite a life expectancy to go.

Now, for any of the medications that you take or she takes, are there any generic alternatives that you can take?

Mr. ROY. Whenever the doctor makes out the prescription, he always writes "no generic." He doesn't want generic.

Senator COHEN. He doesn't want generic?

Mr. ROY. No, he doesn't.

Senator COHEN. In case you can't hear back here, the doctor does not want to prescribe any generic alternative for the medications that are prescribed. By my calculations, the Cardiogain that you have to purchase has increased some 66 percent in just 2 years. Have you found that that is true with the other medications that you have to purchase?

Mr. ROY. Yes. Now, I'm not going to tell you that they don't have a generic alternative.

Senator COHEN. But that increase—in just 2 years, it's gone up 66 percent. In fact, we have a chart over here that's been prepared

so those of you in the audience can see this. We have a medication or drug that could be purchased back in 1980 for $20. In 1991 it's now $53.76. By 1995, if the current rate continues, it will be $77, and by the year 2000, just 8 short years from now, it will cost $120.88 for the same medication. And the problem with that, of course, Mr. Roy, is that you indicated you have a supplemental insurance Medigap policy, right? But your policy doesn't cover prescriptions, right?

Mr. ROY. No, it doesn't.

Senator COHEN. And we should make note of that, that although Medigap insurance is offered and sold to many senior citizens, the majority of the Medigap policies do not cover prescription drugs, even though many people are under the impression they do. The cost of that Medigap insurance, or course, is going to be much higher than those without it. So it's a Catch-22. If you have Medigap insurance, in order to cover the prescription drugs, the cost of the Medigap insurance may be beyond your reach to pay for it. So you ordinarily have an exclusion for that, and the premium will come down, but you won't have the coverage?

Mr. ROY. Yes.

Senator COHEN. He just pointed out the so-called Catch-22 that in order to afford the coverage or the policy itself, it would cost you more to provide for the insurance than it would for the purchase of the drugs.

Thank you, Mr. Roy.

Mr. Graham, could I just ask you a few questions? From your testimony, it appears to me you've tried very hard to anticipate changes in health care coverage and the needs that you and your wife would have during your days of retirement, but I'm sure you didn't count on prescription drugs escalating at the rate they have been over the past decade. As I read your testimony, your wife's out-of-pocket drug expenses increased about 130 percent in just 2 years. Does that sound right to you?

Mr. GRAHAM. I think so.

Senator COHEN. Have you had an opportunity to discuss other drug alternatives with your physician or pharmacist?

Mr. GRAHAM. No, I pretty much go with just what he dictates. Most of them, I have found, that we need, there is no generic drug replacement. My Blue Cross policy will pay 100 percent reimbursement on generic drugs and 80 percent on nongeneric drugs.

Senator COHEN. Your situation, I think, is an example of the problem that we're presented with. Many people say instead of trying to control the increase in prices of drugs, why don't we just have insurance take care of it? And the problem is that if we just deal with insurance taking care of it, the cost of insurance is going to continue to go up to the point where employers like yours, who had a nice retirement plan for you, will say, "We can't afford your plan any longer because the costs are too high; therefore, we're cutting back on the plan." So even though you have "insurance," you're going to find as long as the cost continues to go up, all we're doing is shifting it from the individual to the insurance company, who will then raise the price, because they're not going to bear the cost of that, or shift it over to the taxpayer, the general Treasury, and if we do that, then the cost is going to continue to go up with-

out abatement, and we're not going to be able to pay for it through taxes, either. So it's a never-ending problem trying to shift the costs rather than deal with why the costs are escalating as rapidly as they appear to be based upon the evidence.

Mrs. Zimmerman, I want to ask you a couple of questions. You indicated that you have two prescriptions. Would you mind telling us why you take this medication?

Mrs. ZIMMERMAN. Feldene I take for osteoarthritis.

Senator COHEN. Do you go without that medication from time to time?

Mrs. ZIMMERMAN. I don't go without it, but I'm only able to get half a prescription, so I sort of have to decide between paying for my medication and paying for my other monthly bills. And I'm really fortunate in that I'm still able to work, and that helps me meet all my bills. So my plight is not as desperate as others.

Senator COHEN. As I recall, you did give your age at the beginning, didn't you?

Mrs. ZIMMERMAN. I'll be 76 on my next birthday, September.

Senator COHEN. And there are many, many people in our society who are 76 who are not able to work.

Mrs. ZIMMERMAN. That's right, and I'm really grateful for that, too.

Senator COHEN. You're one of the fortunate ones in that respect, and you're having a great deal of difficulty. What was the other medication?

Mrs. ZIMMERMAN. Sinumet is the other one.

Senator COHEN. And you indicated that has doubled in price due to what you call an improved formula. Have you found the improved formula to be better?

Mrs. ZIMMERMAN. Yes, I must say that it has.

Senator COHEN. And have you talked to your pharmacist or physician about whether or not you could get a substitute for that improved formula?

Mrs. ZIMMERMAN. Yes.

Senator COHEN. Do you have a Medicare supplemental insurance policy?

Mrs. ZIMMERMAN. I have a Medicare supplemental policy, but it does not pay for prescriptions.

Senator COHEN. Do you have any thoughts about how we should control the skyrocketing costs of prescriptions?

Mrs. ZIMMERMAN. Well, I would like to think that it's possible to put generics on the market immediately, which would put pharmaceutical companies in a competitive situation. As I understand it, there is now a 5-year hiatus for recovery of costs, and, beyond that, 17 more years that they are allowed to prevent generics from coming on to the market.

Senator COHEN. As I understand it, there's a total of a 17-year period, in which, once they file a patent application, it takes anywhere from 8, 10, or even 12 years to finally get FDA approval, and so they remain protected from the time of patent application through the 17-year period. We have actually shortened the time in which the generic drug can become available. The difficulty is, since the adoption of that action back in 1984, it allows the generics to come on the market sooner, but as soon as that takes place,

the other drugs go up in price in order to compensate for the competition of generic drugs. So even though you get a generic drug that's less expensive than the original drug, the prices go up on the original drugs in order to compensate for the generics. So it's still a lose-lose proposition ultimately for the consumer. So that's one suggestion, that we ought to make it available quickly, but it doesn't necessarily provide more money for the consumer.

Mrs. Trumble, you've given us some very emotional testimony about your particular condition and what you have to endure each day, and I think you indicated that thanks to your neighbors and friends, they've been helping you pay for food and fuel to help make ends meet. To you, $200 a month in medication, I guess, must seem like quite a bit.

Mrs. TRUMBLE. It's quite a lot.

Senator COHEN. Have you talked to your doctor about generic alternatives?

Mrs. TRUMBLE. I get some generic. Then there are over-the-counter medications, too, which aren't prescriptions, but there's a certain amount of things you have to buy. I have to have eye drops, and they're the kind of things that add up over the course of a year.

Senator COHEN. Thank you very much.

I want to thank all of the witnesses who have come forward to provide testimony. I should tell you that the key challenge to this country and certainly to the Congress is for us to come up with a comprehensive approach to our health care system. We're finding this is one component of our health care system, but it's a major component. Nonetheless, we have to deal with the reality that we are aging as a society and that the problems are becoming certainly subject to more complicated treatments and more sophisticated treatments at very high costs. We have as many as 37 million people in this country who have no health insurance whatsoever. We have to deal with this issue and get everybody covered, holding down costs, and still maintaining quality, and that's a real challenge for all of us to deal with. There are no simple solutions.

I must say, though, that getting some kind of a handle on the escalating costs of medications has to be a key component of that overhaul. We're finding, at least during the committee's investigations, that Americans pay on an average three times as much for medications as do the average European, and its not always explainable or comprehensible how that can be the situation. Many of these companies are, of course, international operations, and so, in my judgment—it may be subject to challenge and it may be incorrect on my part, but I believe that we are in effect helping to subsidize lower prices for other countries. If they've got restrictions and caps and controls preventing any increase in drugs and we have nothing comparable here, then in essence what takes place is, we find that we are paying three times the amount that most others are paying and we are in effect helping to subsidize on an international level lower prices elsewhere, and I don't think that we can really tolerate that situation. Usually, though, we are not given to engaging in price controls. That's not the American way. We want to have a free market, but as I pointed out during the course of my opening remarks, even with a free market, the tax-

payers should not be paying at both ends—one end being to pay for the ever-increasing costs of medications, and at the same time subsidizing companies who are engaged in lower prices.

This testimony is going to be very helpful to me, and I'm taking it back to the Aging Committee, and not only to the Aging Committee, but I wanted to point out during the course of my remarks that this affects all of us. It affects that young boy who for the rest of his life will have to pay $1,200 a month for medication, and there are tens of thousands of people across this country who have problems of a similar magnitude.

So your testimony has been very helpful, and I might point out for the benefit of the audience, we're not only holding hearings to allow testimony to come from citizens who are impacted by the high cost of medication. The drug industry itself, the pharmaceutical companies, will have an opportunity to present testimony in other committees here and in Washington as well. We want to take as balanced an approach as we can, and we're not here simply to beat up on the drug companies as such. We've got a major crisis in our country, and we've got to find a way that we can deal with a system that we promote across the world—that is, free enterprise in an open and competitive society. We have to do that, but also we've got to provide some protection to people like Mr. Graham, Mr. Roy, Mr. Rawley, Mrs. Zimmerman, and Mrs. Trumble. Individuals that reflect a wide variety of our people, all of whom are for the most part, on fixed incomes. Some have provided their retirement and yet find themselves in special circumstances and are not able to cope with these prices.

Thank all of you for your testimony. We're going to have two more panels testify this morning, and we'll take a break for just a couple of minutes before the next panel, which consists of physicians, pharmacists, and a registered nurse.

[Recess.]

Senator COHEN. Our next panel of witnesses will represent the perspective of health care providers. We're going to hear from two pharmacists, Billy Miller of Bangor and John Desjardins from Bath; Dr. Gregory O'Keefe from Vinalhaven will give us a perspective from a physician engaged in active practice; and Dr. Roger Hickler will discuss his expertise in geriatric medicine and the effect that prescription drugs have had on the elderly; and Ms. Patricia Eye, also from Bangor, will give us her perspective as a registered nurse working with hospice patients.

I want to welcome all of you for coming here today, and we will begin with our two pharmacists. I'm going to forewarn our two pharmacists that during the break, I had a gentleman named Ronaldo Garand ask me a question about a drug. This particular medication, is called Ventalin, and they supplied it to him at the hospital for $7.50, and he went to his pharmacist and it was $21. He would like an explanation as to why that is so.

Mr. MILLER. Do you want it now?

Senator COHEN. We'll wait until after we have your testimony. Mr. Miller, why don't you begin.

I should say I have a bit of a conflict of interest here with Mr. Miller. His family runs a drug store in Bangor, Maine, and I have been a friend of the family since I was the age of, 3 or 4,

and I used to not only have my sandwiches going to grade school at his folks' store, but I continue to actually shop and get medications whenever I need them at their little drug store. So I may be overly rough on you during the course of these hearings to compensate for that.

Mr. Miller, why don't you begin.

STATEMENT OF BERNARD W. MILLER, PHARMACIST, BANGOR, ME

Mr. MILLER. Thanks for the opportunity to present the case of the pharmacists. I do have a prepared text, like everyone else, and I will stick to it; however, I had a hard time sitting on my hands or keeping my mouth shut during the first group of testimony, and I'd like to take an opportunity to offer some advice to some of these citizens, but I will hopefully cover some of it in my testimony.

I have been a pharmacist for the State of Maine for 35 years, and as Billy said—we both have the same first name; my name is Billy and his name is Billy, and we still go by it—senior citizens account for the largest percentage of prescriptions filled in pharmacies today. I have witnessed the increase in the average prescription price over the past 35 years and am of the opinion that in many cases, the increases have been unreasonable and unaccountable. Senior citizens live on a fixed income, and their incomes cannot keep up with the high cost of health care in general. Granted, people are living longer and enjoying a better quality of life because of modern pharmacy; however, this does not give the manufacturers open season on the pricing of medications.

Many senior citizens actually don't have enough money for the proper groceries each month. Medication that is out of patent should be priced lower and newer medications need to be priced with more sensitivity to the senior citizen and to all citizens' incomes.

One solution to the high price of prescription medicine is to eliminate multi-tiered pricing—that is, selling to hospitals and the military at a lower price than to the retail pharmacy and then getting even by charging a higher price to the retail pharmacy. The medicine that you have in your hand, I believe, if I'm not incorrect, costs the hospital around $3. It is supposed to be used only in the hospital. It is not for resale to the public. Whoever sold that to this gentleman for $7 jeopardizes his future in pharmacy, because I believe it is illegal. The elimination of multi-tiered pricing, I feel, is imminent.

Another way to control the high cost of prescriptions is through a closer relationship among the patient, physician, and pharmacist. Doctors must be sensitive to prescription prices, and when they prescribe they should realize the cost of the medication and possible alternatives. Is there a less expensive medication that will have the same results? Should he write a small prescription in order to make sure the patient is not allergic or that maybe the medicine will be ineffective and a new medication prescribed? Thousands and thousands of pills are wasted because people have allergic reactions and they had a large prescription. Try a week's supply if

possible. There are a number of ways that a physician can lower the cost of the prescription if he will consult with a pharmacist.

The physician is encouraged to write for larger supplies, such as a 90-day amount. This is especially encouraged for maintenance medications and by mail-order pharmacy. As a result, the waste is astronomical and much medication is thrown out because of reasons cited in the previous paragraph.

Since our Government, through Medicare, Medicaid, and other health plans, is actually paying the bill for so many of our senior citizens, I feel the Government needs to look at the manufacturer and its pricing structure. We are told what they will pay us. The Government, the different agencies, insurance companies know exactly what I pay for medication. It's no secret. But it is a secret what the manufacturer pays, and I think it's time that they opened their books.

There is no question to the statement that today's prescription is a bargain. People live longer, people live better. However, when the prescription price takes food off the table and very often the price can be over $100 for an antibiotic or ulcer medication or $40 for nitroglycerin patches or $60 for blood pressure medication, we need alternatives to these high prices.

Just recently a new drug has been released, and even though it is not used by the senior citizen population, in a large way it is a good example of today's pricing method. This new drug is known as the nicotine patch. It is manufactured by three companies, and coincidentally all three charge about the same, the high price of about $115 for a month's supply.

When discussing the high price of these patches with all the manufacturers' representatives, I commonly got the answer that cigarettes were expensive, so if you think about the price you are paying for cigarettes, then the patches are a bargain. Well, I feel that that's not an appropriate way to price a new drug.

Another way to reduce the cost to the patient is to prescribe some of the oldie-but-goodie medications. New is not always better. I think an example would be the new expensive ulcer medicine. For $4 or $5 a patient, you can get a prescription of Donatal, a prescription of Belladonna drops, to maybe take care of their problem. Then if that doesn't work out, go with the new expensive medication. But there still are many old-time medications that are out there that are still good.

Senior citizens like to eat, but they need their medications. Let's face it, many senior citizens have little money left after they've paid for their monthly bills, and if health care were at a level that would fit into their income, these same clients would be able to enjoy more of the luxuries of growing old.

Thank you.

Senator COHEN. Thank you very much, Mr. Miller.

Mr. Desjardins.

STATEMENT OF JOHN DESJARDINS, PHARMACIST, BATH, ME

Mr. DESJARDINS. Senator Cohen, ladies and gentlemen, it's my honor to be here. My name is John Desjardins, and I have been a pharmacist since 1971.

Over the last 20 years, prescription prices, like other goods and services, have escalated. When I began working, the average prescription price was about $5.50. Today's average price hovers around $22.50. This figure, although much higher, scarcely reflects the inflation rate over this same period of time. For many years, ethical drug manufacturers kept prices relatively stable. Historically, prescription prices lagged well behind other health care costs.

Things have changed. Prescription prices have risen dramatically over the last few years and have become a hot news item lately. It is my observation that the escalation of drug prices actually started when the Government implemented its price controls during the 1970's. Prescription costs seldom changed more than once or twice a year before that time. With the new Government policies, despite their intent, they laid the groundwork for an acceptable systemized method of raising prices over specified periods of time. Guidelines to limit prices were based on percentages that manufacturers used to raise prices several times in the course of a fiscal year.

Today's price changes are often weighted differentially across an entire product line in order to bring the final across-the-board price increase to below or equal to the CPI. If the CPI or other indicators allow a 3.5-percent increase, for instance, many drug manufacturers will weight their price changes to include higher percentage increases on their premium, more highly promoted products, while using a smaller increase on the less-profitable, less-promoted products. This obviously leads to a higher cost for the most widely used medications and hence generates a greater profit for the drug manufacturers.

Of course, I realize these are prudent business practices and that the word "profit" is not a dirty word. I also realize that the drug industry as a whole spends more money on research and development perhaps than any other industry. There are very few aspects in health care development that can say they have improved the quality of life the way drugs have. Many of the new drug entities on the market today are truly miraculous. The problem, however, as I see it, is that the burden of the expense of research and development and high corporate profits falls on the shoulders of those who can least afford it—the elderly.

When a new drug entity comes into the market today, the innovator company sets the bench mark for prices of any drug to follow in that category. It would be of great interest to me to know how this initial price is determined. The obvious considerations include cost of materials, research and development, promotion, marketing, distribution, et cetera, all of which can be clearly calculated. What cannot be calculated with any certainty is the intrinsic value of this new medication to society.

I once read in a pharmaceutical journal that the advent of the beta blocker would drastically cut down hospital patient stays to the extent that hospitals would find themselves in financial difficulty. The social and medical advantages of these wonder drugs have been truly remarkable. Who can calculate the value in terms of dollars and cents and justify its inclusion in the final cost of a new drug? Is this value just an arbitrary figure?

Consider the introduction of a new drug—let's call it "A"—which is the first of its kind on the market. Let's also assume this new

drug is twice as effective as any previous therapy. Now, let's position our new drug pricewise at twice the price of the old therapy. For the sake of illustration, I will use a price of $25 per bottle of 100. The required dose of drug "A" is one tablet four times a day. This results in a daily cost of $1 or $30 per month. This is the new benchmark price. Drug "B" enters the marketplace in the same category but has the advantage of twice-a-day dosing. The patient now can buy less medication per month, improve compliance in regard to taking the medication properly, and therefore should receive greater therapeutic benefits. In determining the price of drug "B," we already know that drug "A" sells for $1 a day, but since drug "B" offers significant advantages, the price will be $1 plus an advantage fee on the dollar of, let's say, 25 cents a day, bringing it up to $1.25 per day of therapy. The same would apply if a drug "C" comes into the marketplace as a once-a-day therapy. Again, there would be an advantage fee applied based on what the market is currently paying.

I'd like to add something that's happened recently that would be of interest in regard to that scenario. You will see a lot of ethical drug companies now advertising on TV at prime time. The nicotine patch is a real big one, and resulted in an increase in phone calls at my store of 5 to 10 calls a day. You hit the consumer right there, and they wanted more information on pricing, et cetera. Of interest to me, though, more than that lately, was the new one by the Cardizem people, and they have directed their advertising to the consumer on the television, and this has also generated more calls. There's a statement in the ad that says "Consult your pharmacist or your doctor. There may be a significant cost savings," and so I've had two calls just yesterday. The interesting thing is that this exactly fits my scenario outlined above. The other interesting thing, and the thing that really bothers me, is that I know at the end of the March, prior to the ads coming on TV, prices on the Cardizem product line went up, and this does two things. It ensures the accuracy of their ad on television, and it manipulates the market, and that tends to bother me a lot.

Anyway, to continue with my statement, the above is a consistent repetitive event in nearly every category of pharmaceuticals. There is no reason to assume that the cost of manufacturing increases with longer acting medication, whether it is a different compound or a new formulation of the original drug. As soon as any drug in any category goes up in price, you can be sure that all drugs within that very same category will also rise, maintaining their relative cost positions within that category.

As we age, the need for drug therapy often increases. It is not uncommon for the elderly to be on five to six different medications. The out-of-pocket expense can be great, and the elderly's limited ability to pay for them often puts them in a position of choosing to improperly decrease their doses, thereby often losing the beneficial effects their medication was designed to do. It is also a time in their lives when fixed incomes are not adequate and in most cases, their health insurance carriers drop their major medical drug coverage coincident with signing up for Medicare.

Each drug company, by strategically calculating its cost with category pricing, social impacts, and raising prices with weighted

averages places a weighted tax on elderly multiple drug users. Their ability to pay is limited, and their debt to society has already been paid by leading productive lives prior to fixed income living. To grant the drug manufacturers tax credits and ignore the needs of the elderly is deplorable, and the Government should not stand for it.

Senator COHEN. Thank you very much, Mr. Desjardins.

Dr. O'Keefe.

STATEMENT OF GREGORY O'KEEFE, M.D., VINALHAVEN, ME

Dr. O'KEEFE. Thank you very much for letting me testify before your Committee, Senator Cohen.

I have practiced in Vinalhaven for about the past 20 years and dispensed through a dispensary—they're not an actual pharmacy—about $150,000 worth of medications per year. These medications are sold by our town, which owns our facility, in a nonprofit way.

That hasn't lessened the burdens of the expenses, and I think what has happened in Vinalhaven echoes the experience that others have had that back in the late 1960's when I started in medicine, medications amounted to perhaps 10 percent of the office call; now medications may be 200 percent of the office call. For chronic patients, the medications may be so costly as to severely impinge on their discretionary income. And as everyone has said, Medicare recipients are the group receiving the most prescriptions, but every group has noticed unbelievable and really unbearable price increases when they fill them.

It's very painful for me to stand at my desk and watch a patient be charged $40 for the office call, which is high, but $96 for the medication. In fact, when I hear that, I'll often reconsider and say let's do something else. It really is scary. A fulfilled fear that I have is that patients are neglecting their other needs to purchase their expensive medications and/or are failing to fill those prescriptions due to those excessive prices.

Some patients have addressed the issue by seeking out mail order or telephone drug companies or chains, but they've often found that this effort is difficult and they're unable to save that much money. They may go on surreptitious drug vacations or they may leave medical care for a while.

I encourage physicians to be aware of the prices of their different medications and to weigh the necessity of the prescription against its potential benefit. For example, is Ceclor or Augmentin, two fancier antibiotics at $50 to $60 a course, truly necessary versus Amoxicillin at $6 or Naprosyn at $2 to $3 for arthritis really and truly for that patient going to be better than aspirin at 2 to 3 cents a day?

In 1972 I might have been able to treat a patient who had congestive heart failure for approximately $2.40 a month, being able to buy 100 Monoxin in 1970 for $1.20. Those medications are becoming passe, and often the medical literature says that persons with congestive heart failure shouldn't be treated with these old drugs. But now those diseases might be treated for upwards of $240 per month, different medications and possibly much more effective.

In 1972 the treatment for Parkinson's disease may have only been $5 a month with the medication called Cogentin. This was not a very effective medication, and the new drugs that are now available are far superior, but those patients may pay $200 a month for this treatment. I find this a very terminal dilemma, and referencing what Mr. Miller said, physicians should really avoid therapy-lock, meaning ordering 3 months worth of medication for a patient when only a week might be a good idea to see if that medication is tolerated or is effective.

How can patients not feel pressed by the accounting of $400 in prescription prices per month and the predictable $600 or $800 Social Security benefit? That seems to be an average benefit, I'm finding. I typically asked my last 15 Medicare patients about their medications and the cost, and the average well patient who sees me every 3 months spends approximately $100 per month year-round The sicker patients are spending $200 to $500 a month.

To address this crisis, the State of Maine, with the Elderly Program, the Medicaid program, and major medical programs, have truly helped many, many patients. The retail pharmacists in our area have cut their profit margins substantially, I know. However, the base drug prices are just so high that there is very little alternative to that patient who has been educated about the new miracle drugs and the doctor who really wants to do what the patient has heard about on TV and wants to prescribe if that's the most current medication for his patient.

I have a patient who has systemic lupus arapenotosis, a difficult diagnosis, and she takes the drug called Methyltrexate, a potent antiarthritic. In Maine or anywhere in the United States, for that matter, the best price we were able to find was almost $270 per month, but she had a friend who had a friend who had the same disease, and they're able to get that medication in Quebec for $70 a month, and the folks up in Quebec are willing to accept a Maine prescription, so we're happy about that.

The bill that Senator Cohen has introduced to limit price increases and limit profit margins by drug companies operating in Puerto Rico is really a very good and beneficial one and is an excellent start to this thorny problem. I'll digress a little bit with a few other suggestions, out of context of the bill. I think that more education and perhaps alternative advertising, perhaps at the expense of the drug companies, of the fact that the new drug is not necessarily better than the older, cheaper drug, and one thing I'd be interested in hearing was what Mr. Miller was referring to, but I think ever greater numbers of "safe" medication could become over the counter at pharmacies. There's a drug called Mycelex, which has become over the counter, and I think that story has been a great success. It's limited many, many office calls by patients, as has the liberalization of allowing Actifed and Hydrocortisone to be over the counter as well.

Specifically, I'd suggest that over-the-counter could be sold Tagamet and many of the older, simpler, cheaper antibiotics. In the case of Tagamet, for example, this is a potent antiulcer drug, and over-the-counter formulation would result in a better price possibly and could eliminate that expensive office call, and if the doctor referred that patient on to a specialist, he could avoid hundreds of dollars

worth of tests that, in all honesty, would probably be unnecessary. In the case of antibiotics, there are many parents here in the group, and they know often what their child's problem is very well, and they don't feel too great about the big office call, the big throat culture, et cetera, when all they know is what they need is a bottle of Amoxicillin for the young lad.

These efforts would take the strain off of patients' budgets who must spend $40 to $100 in office calls to get Tagamet or $40 to $100 in office calls to get a course of antibiotics for ear infections, sinusitis, colds, or urinary tract infections. The pharmacists would be as helpful as they have always been with their responsibilities, and they would provide over-the-counter warnings to patients. Surely liberalized over-the-counter medication would bring down all health care costs, and it is extremely doubtful that much illness would result from this policy. There are always exceptions.

Lastly, several final health care containment suggestions. I think all physicians should be on salaries. I think that there should be one set of rules for all Americans in terms of an insurance plan. I think there should be a physician draft for underserved areas and groups. There should be decreased dollars for the high-priced procedures, and all physicians should accept Medicare assignment.

In summary, I think the best lobbyists for a balanced medical care system are patients. They can educate our legislators as to what is reasonable. They always should remember, however, that good health care costs more than poor health care.

Thank you very much.

Senator COHEN. Thank you very much, Dr. O'Keefe.

Dr. Hickler.

STATEMENT OF ROGER B. HICKLER, M.D., CAPE ELIZABETH, ME

Dr. HICKLER. I, too, would like to thank Senator Cohen and his staff for the invitation to participate this morning.

I'd like to start with a quote from something I wrote a few years ago entitled "Emergency Problems in the Elderly", but I think it's relevant to the problem under discussion by this panel.[1]

The proportion of the American population over the age of 65, currently given as 11 percent, will double over the next 50 years. It is estimated that the elderly utilize 30 percent of all prescribed drugs, and studies on the noninstitutionalized elderly indicate an average of three to four drugs being used per person—two prescriptions and nearly two over the counter. Nursing home residents have been identified as receiving on average seven therapeutic agents per capita. The most obvious reason for this "polypharmacy" is the multiplicity of clinical disorders for which drugs can be prescribed, as shown in a study of geriatric patients where 77 percent had one to three diagnoses and 23 percent had four or more diagnoses. In order of frequency, these are cardiovascular diseases, including hypertension, arthritis, gastrointestinal disorders, and central nervous system trouble. Another major reason is the chronicity of these diseases; long-term drug therapy becomes the rule.

[1] From Medical Economics Books, Oradell, NJ, 1985.

Given this background, it is not surprising that the prevalence of adverse drug reactions is about seven times higher in the elderly than in the young, being directly proportional to the number of drugs taken. By the same token, the opportunity for adverse drug-drug interactions is much higher in the elderly. It has been estimated that 3 to 5 percent of all hospitalizations are for adverse drug reactions and that 30 to 50 percent of all patients experience one or more adverse drug reactions during hospitalization. The length of a hospital stay is nearly doubled by such reactions, and the prevalence of the problem is much higher in the elderly. An estimated 30,000 deaths and 1.5 million hospitalizations per year result from these events at a cost estimated between $1 billion and $3 billion per year.

At a time in life when long-term drug therapy is most required, many can least afford it. We all know that prescription drugs are costly. Some of the most important are exorbitantly, if not prohibitively, expensive. Even with the reduction in cost from Social Security benefits, this remains true.

Let me paraphrase a recent comment from a colleague, who is a cardiologist, who said in effect, "I shudder every time I have to prescribe some of the newer and highly effective cardiovascular drugs for my not-so-well-off elderly patients." That's one point that's well-taken. It was a common experience in my Geriatric Clinic at the University of Massachusetts Medical Center for an elderly patient to arrive with a paper bag full of half-empty bottles of discontinued pills, many overlapping in their effects, some over the counter and some prescribed by several physicians. Most of the drugs were poorly understood as to their purpose by these bewildered elderly patients. The problem of high drug costs and poor utilization by many elderly patients is common knowledge to health care providers.

Senator Cohen's office has asked that this panel consider possible solutions for the problem of cost containment. There are several levels at which action may be taken, and I'd like to review three such levels with which I've had personal experience.

I'll start with the doctor's office. The physician perhaps should, one, be sure that each medication in use or being prescribed is strictly indicated and not overlapping. There is a suspicion that physicians in general tend to overprescribe. The fact is that some do and many don't. Two, educate our aging populace to ask hard questions of his or her physician. How does this medication work? Are there less expensive but equally effective forms of the same thing? Will it upset my stomach? If the response is unsatisfactory, the patient has every reason to seek medical attention elsewhere. Three, always use the generic form if possible. It is usually less expensive and gives the pharmacist some latitude. Four, carefully explain the purpose and potential side effects of the drug in question. This comes under the important topic of patient education. Patient compliance, an unfortunate but commonly used term, will be much better and should facilitate cost containment in the long run. Five, prescribe in lower dosage than in younger patients, since the elderly metabolize most therapeutic agents more slowly. The potential for side effects to be eliminated and total expenditures reduced is implicit. Finally, have a listing in the office of the cost of the commonly prescribed drugs according to class, such as analgesic, antihypertensive, psychotropic, and so on.

Most physicians—and I'm as guilty as anyone of this—are only dimly aware of the precise charges for these medications. Where a

less expensive medication will do just as well, it should be preferred. It's been said previously, and I certainly support the concept that the time-honored aspirin may be just as effective as some of the more expensive, newer so-called nonsteroidal anti-inflammatory agents in the chronic management of the disorders which really aren't going to disappear but for the relief of the discomforts of things such as degenerative joint disease, which I think affects 95 percent of people my age and older anyway, and so it's common. Certainly our colleagues in the pharmacy profession would be willing to provide such a listing on request.

Second, I want to discuss potential ways to reduce costs through pharmacists. Certainly be sure to point out to clients the potential for cost reduction of drugs through Social Security benefits or a major medical insurance policy. Certainly have no reluctance to call the physician who may have absent-mindedly used a trade name rather than the less expensive generic designation on the prescription. Have no reluctance to call the doctor if he or she discovers the patient is getting the same active ingredient in differing forms and in several medications, which may have escaped the physician's attention.

Finally, with regard to the pharmaceutical industry, the measures proposed above, while reasonable, are not likely to impact as extensively as one would wish on the major problem, which, of course, is the high cost of drugs per se. Certainly the industry's position is clear. The industry will point out that in a society which embraces a free market economy, the development of new therapeutic agents is a very costly and at times risky business, and that such expenses need to be recovered once the drug is marketed under its trade name if the company is to thrive and protect the interest of shareholders. Having participated in detailed and expensive clinical trials of new therapeutic agents supported by the industry at a university medical center, I can vouch for that fraction of the total cost as required on the long road to Federal Drug Administration approval, but off the record I can also vouch for having received many items such as Senator Cohen held up this morning, an office full of things such as unnecessary clocks and pen holders and even stethoscopes and so on. The marketing costs are out of sight.

Finally, the regulating function of Government. It is evident that the Federal Government, while committed to the preservation of a free enterprise system, also has a responsibility for the well-being of its citizens. I admit, Senator Cohen, that I was unaware of your bill, and I'm pleased with that effort. If I may be anecdotal for a moment, let me cite a recent experience. On purchasing some capsules of a broad spectrum antibiotic at a local pharmacy for personal use, I was informed that the price to be paid was about $40. After I produced a card showing my major medical coverage, the price was reduced to about $8. If the industry is still making a profit at $8, then am I correct in assuming that at $40, the markup is several hundred percent? If that's true, is that fair to a customer of limited income who doesn't have the option to decline on the grounds of cost, since the medication is considered to be essential?

Many of you will recall the congressional hearings held on this subject a number of years ago by the Kefauver Committee. I do not

know if any effective legislation derived from this effort, but the central question remains, can the pharmaceutical industry be induced to reduce the price on well-established and regularly required prescription drugs to a level that, while profitable, is more reasonable?

In conclusion, obviously, the high cost of drugs is a small but important part of the larger issue of the burgeoning costs of health care in general. Certainly at a time when entitlements to the elderly under Social Security are likely to be curtailed rather than expanded in the interest of national solvency, the problem promises to worsen rather than improve. While it is tempting to fault one part of the health care industry, the current crisis is not a matter of fault by any particular component of the system. To a great extent, it is the product of the high cost of the same technological advancement at all levels that lead to its excellence. Thus, more profound solutions must be conceptualized if any substantive improvement is to be realized. I seriously doubt that more and more regulation of the system as it now operates will solve the problem.

Thank you.

Senator COHEN. Thank you very much, Dr. Hickler.

There are many, no doubt, in the audience who have held the belief that somehow physicians were in collusion with pharmacists, and Dr. Hickler has just destroyed that myth, and we may find out exactly what the pharmacists have to say in terms of some of the questions he's raised today.

Ms. Eye.

STATEMENT OF PATRICIA EYE, R.N., BANGOR, ME

Ms. EYE. Thank you, Senator.

My name is Patricia Eye. I'm a registered nurse, and I'm currently working in a hospice program, a newly Medicare-certified hospice program. I am acutely aware of the detrimental effects of the high cost of prescription drugs for the elderly.

Among the distressing stories that I hear from patients and families and from other nurses, particularly home health nurses, the following scenarios are typical.

There is the patient with a small Social Security check and no other income who tells her nurse that she'll have to make a serious choice between eating and taking her medications. We've heard that.

There is the gentleman newly discharged from the hospital who tells his nurse he won't take the medicine because he doesn't have the money. The nurse knows that the consequence will be his returning to the hospital. She speaks to the director of the agency and together they split the cost of the medication, thereby keeping him at home.

Then there is the story of a home health client who has been hospitalized and is now being discharged home. A family member complains to the visiting nurse about paying $200 or more for the medicine previously prescribed and wonders why nobody bothered to find out what the patient had on hand at home.

Or a patient at home develops an infection and is prescribed the appropriate antibiotic for the appropriate length of time. The anti-

biotic is very expensive. After 2 days, he develops symptoms related to the antibiotic and must try another antibiotic, equally as expensive.

An elderly lady lives independently at home. She receives Social Security in the amount of $500 a month. Her medications average between $200 and $300 a month. She must use her savings to meet expenses. Because she does have savings, she does not qualify for the Low-Cost Assistance Program for the elderly.

Perhaps most touching is the story of the terminally ill patient at home whose chief problem is pain. When his pain is not relieved, the nurse discovers he has not been taking it as prescribed on a regular basis. He says he fears he will become addicted and so he only takes it when he really needs it. Upon further questioning the nurse discovers that he considers the medicine very expensive and that paying for it along with everything else is costing him more than money. He is in emotional distress wondering what will happen to his family when he is gone and has depleted the financial resources.

The visiting nurse tells a story that shows how increased drug costs also increase the cost of resources. A home patient needs daily injections of a drug to control osteoporosis and its accompanying pain. The nurse is to visit monthly, assess the patient and fill the syringes for 1 month's time. Because the medication is very expensive, the family can buy it only in small amounts. The nurse responds by making her visits more frequent.

When I worked in the hospital setting, it was not unusual to see patients with chronic diseases return frequently to the hospital. It was also not unusual to hear them labeled "noncompliant"—the truth being, in many cases, that they could not afford the medications prescribed.

I now work in a Medicare certified hospice program. Since we pay for those medications related to the terminal illness, I have become very aware of the cost of these drugs. In some cases where pain is the problem, it is not uncommon to expect that at least one-third of the money for routine care reimbursed by Medicare will be used for prescription drugs.

These are some of the problems that we as health care providers encounter. There are some solutions, as well.

Hospital discharge planners need to discuss prescription drug costs with patients and help them to apply for low-cost drug programs.

Nurses responsible for explaining medications to patients who are being discharged need to ask what they have at home.

When new medicine is prescribed, the amount of pills dispensed should be small so that it can be determined if the patient will tolerate the drug.

Discharge planners and home health nurses should make themselves aware of the pharmaceutical companies who offer free prescription drugs to patients who qualify.

Patients need to speak up and ask about cost. If trying a medication for the first time, they should not be afraid to ask their physician for samples.

In conclusion, we do need to have research continue, and this is costly, but there needs to be some limit setting in passing that cost on to the very ill consumer.

Thank you.

Senator COHEN. Thank you all very much.

Let me offer some general comments initially. There is a lot of misunderstandings on the part of patients and consumers and taxpayers about the whole issue of the health care industry. There is misunderstanding between the patients, for example, and doctors and their relationship to pharmacists. The fact is that doctors are not experts on pharmacological matters, and they depend upon other experts. As a matter of fact, I would for example, compare it to what politicians are like. I am not an expert other than I used to practice law and I know a little bit about the law. I am not an expert in the thousands of issues that I have to deal with every year. So who do I depend upon? I depend upon lobbyists in many instances to come forward to present their side of the case, their side of the issue, to inform me. I get lobbyists on all sides coming in, and hopefully I can make an informed judgment. I depend upon staff to keep me advised on various issues, and I depend upon experts on medical issues like Dr. O'Keefe or Dr. Hickler or someone else to come forward and tell me about their opinions.

Doctors find themselves in a situation where they have literally a blizzard of advertising materials, and the fact of the matter is that they may have something that's advertised that will call their attention to a big new drug. They may go to a seminar, as a matter of fact—Dr. Hickler talked about this—and be educated about the benefits of a particular drug. What they don't know, as Dr. Hickler pointed out, is how much it costs. They have, I would venture to say, very little idea on a day-to-day basis the cost of anything that they're prescribing other than they know what result it's likely to produce based upon the literature that they receive.

So one thing that we all have to understand is that while doctors are almost all-knowing, many times they don't know in fact what the cost is of something they're prescribing for their patients and don't know whether there is something that's a reasonable alternative. Dr. Hickler said perhaps it would be nice if Mr. Miller and Mr. Desjardins gave them a copy of a price list so that they could make a comparison on virtually every drug that they prescribe. Maybe that's something Mr. Miller will want to respond to.

Mr. Garand has raised an important issue about this inhaler. He said that basically it's the pharmacists who are at fault here, and you are the people who, every time they come in for a prescription, they blame you for the high cost. They say, "How come this costs $7 at a hospital and it costs $21 in your shop? Explain that to me."

Mr. Miller, you started to explain that, and I'm going to give you a chance to do precisely that, because he mentioned something called multi-tiered pricing, and I'm going to have him explain this in terms of how is it possible that you can get something from a doctor, maybe a sample given to them, or from a hospital, which maybe the samples given to them, and yet it costs so much when you get it through a pharmacy? Is the pharmacy in fact making a tremendous profit or ripping off the patient at this point? That's a sentiment that's out there, it's very strong, and I think what we

have to do while we have the opportunity of having doctors and nurses and pharmacists here together is have some explanation for the record.

Mr. Miller, explain again how something like this can cost $7 through the hospital doctor and $21 at some pharmacy other than Noah Drug.

Mr. MILLER. This is probably one of the best examples of multi-tiered pricing. Maybe I set this up. [Laughter.]

The size of this package is 6.8 grams. So the size that we have in the retail pharmacy all over America, every drug store chain, independent, Bangor or Vinalhaven, is 17 grams. This is exactly one-third the size of the Ventelen that you get in the retail pharmacy. So this is not an example of multi-tiered pricing. This is an example of either the hospital—I don't know if this is a sample or if it's a hospital package that I'm not aware of. In any event, we in the retail pharmacy pay about $18 for this. That's what the average wholesale price is. Now, these Government agencies know that I get a discount if I pay my bills on time. They also know that I get a discount for buying from them. So probably the low, low price of acquisition, which is different than the average wholesale price, would be around $16. So if I sell it for $21 and I've made $5 on it, I feel that that is a fair profit for me or any other pharmacy, and that's about what we sell it for.

Mr. GARAND. It's a bigger profit on that.

Mr. MILLER. A bigger profit on this because it says "Professional Sample, Not For Sale." So that guy is in deep doo-doo, because that is against the law.

Mr. GARAND. What he has in his hand now, my doctor gave me. When I left the hospital, the hospital billed me on a paper like this $7.50 for a full inhaler.

Senator COHEN. Let me just explain that the sample that was given to you, you were not supposed to be charged for that.

Mr. GARAND. He didn't charge me for that. I went to the hospital, the hospital sent me a bill saying one inhaler, $7.50, which is a big one. So why do I pay $21 at his store?

Mr. MILLER. I'll answer that.

Senator COHEN. Mr. Miller, would you care to answer that?

Mr. MILLER. That is a good example of multi-tiered pricing. That means that the hospital, Government agencies, and other agencies that I can't think of at this time pay a special price, the reasoning being that hopefully the hospital and the doctors in the hospital will then prescribe the medication, and then the patient goes home and brings the prescription to the pharmacy and then buys it, and hopefully not be aware of the multi-tiered pricing. Multi-tiered pricing is not commonly known; however, it should be, because one of my recommendations is that multi-tiered pricing does not belong in any way in the drug industry.

Senator COHEN. So just for the record, then, in the first instance, a doctor might hand this to a patient and say, "Try it," and that's perfectly legal.

Mr. MILLER. Right.

Senator COHEN. The hospital, on the discharge of a patient, can say, "Here is a full vial of this, of 17 grams, and we're going to

charge you $7.50" because they get a very substantial discount if they buy in volume, right?

Mr. MILLER. They pay $2 apiece for that.

Senator COHEN. But they don't refill that prescription. The patient has to then go to the pharmacy to get it refilled. One of the things that drug companies do, like other businesses, is try and get you started on a particular drug, and they virtually give these away to either hospitals, or large consumers, with the notion that they are going to be prescribed by the hospital or the physician at the hospital so that when you go out into the private sector, to the pharmacy, you will ask for that particular brand of drug, and then the charge to the patient is $21 in this particular case. So it's a way of getting you started or hooked on a particular brand.

Now, many other companies do the same thing in all sorts of food items and other types of consumer items. The difficulty here, of course, is there may not be an option for you in terms of a generic drug. The fact is that through multi-tiered pricing, you have the impression that you're getting ripped off at the pharmacy, when in fact their prices have to be published. Mr. Miller mentioned something else. He said, "How about forcing the drug companies to open their books, to show us how they in fact price things?" Ladies and gentlemen, that's not going to happen. That is simply not going to happen. The drug industry is not about to come into Congress and share its books as such, because they will claim that it's truly an invasion into their privacy as such, their patent mechanism, and how they go about pricing a particular drug and the research and development that goes into it, they are not going to share with their competitors. I will tell you right now it's very unlikely that anything Congress will do will force them to do so. So that's not a viable option, Mr. Miller. I'd like to tell you that it will be——

Mr. MILLER. They look at our books.

Senator COHEN. They look at your books, but I'm just telling you Congress will not do this. We had a hearing over a year ago or a year and a half ago, at which we invited the drug industry to come in, and they absolutely refused to openly disclose matters which they feel are truly protected. They said they would share some information, but not much of it, and I just don't see it as politically viable to say we're going to force this industry to disclose how they go about pricing.

You raised the issue of the nicotine patch, the way in which that's sold, saying, "Here's what it costs by being addicted to cigarettes, and here's what we're going to charge for this patch that will hopefully get rid of your addiction," and that was the explanation given to you. That's not a reasonable explanation in terms of how much money they have spent developing this, and it has no relationship whatsoever to their costs, but it surely does good things to their profit numbers. But again, they're not about to come forward with that information and share it.

I'd like to talk about oldie-but-goodie medications, that approach that you recommended. It seems to me there was an almost unanimous body of opinion here that perhaps the old drugs are just as good as the new. You might get a marginal benefit with some and not with others. I wanted to point out, Mr. Desjardins, you thought

about the cost in developing drugs, and no one can deny that, but there's a case, for example, of Tylenol with codeine. Tylenol with codeine came on the market back in 1977. Between 1985 and 1991, the price went up 128 percent, about a 16-percent increase each and every year. So even though you have the oldies-but-goodies, you're still seeing a fairly dramatic rise in the cost of things that have been tried and true and have been on the market. So that necessarily isn't going to save money, but I think the suggestion that you made that we ought to stay with the old one unless we're satisfied that the new drug does in fact represent a quantum leap over the old drug and warrants a price differential is a good one.

The question I would have for the pharmacists is, are you willing to spend the time and the money to supply physicians with a comparative price list for various drugs and help them make that decision? Dr. Hickler said he simply is not aware of what one drug might cost over the other, or whether there might be a generic alternative available. But is that something that the pharmacists want to do? Many people would say, "Well, the pharmacists like to keep those prescription drugs going, because there's a higher profit margin on those than the generic, so maybe they aren't as willing to share that information with physicians." What's your response to that?

Mr. MILLER. My wise-guy response is, sure, I'll swap price lists. You give me your price list, and I'll give you my price list.

Senator COHEN. Give me your reasonable——

Mr. MILLER. My reasonable answer would be that by far, in the State of Maine, we are required to quote prices for the 100 most commonly prescribed medications, and it would be very easy to just give a copy of that list to any physician. And we are all the time being questioned by physicians about prices. We're not unreasonable. We're willing to share that information, make a recommendation.

Senator COHEN. You both have touched upon this, that maybe the burden should be shifted a little bit to the patient to inquire of the physician, saying, "Is there a better option?" I must tell you that based upon my experience with congressional hearings, the doctor-patient relationship is perhaps the most sensitive that one could have. We had a hearing recently in Washington dealing with overcharges on the part of some physicians and hospitals getting a Medicare reimbursement. I'll just give you a little, brief synopsis of what took place.

Under the Medicare law, there are some physicians who accept— Dr. O'Keefe, you talked about all physicians should simply accept Medicare patients, for example. Well, not all physicians do. We have physicians who in fact agree to accept Medicare as what we call full reimbursement. It's not full, because the patient still pays 20 percent. Medicare only pays 80 percent. But many physicians accept that as full payment. There are other physicians who, while they treat Medicare patients, do not accept that as full reimbursement. Over the years they would charge whatever their charge was, and the patient would get reimbursed by Medicare and pay the remaining amount to the physician.

Congress changed that back in 1989, and we said, "Wait a minute. If you're going to receive reimbursement under Medicare,

we're going to put in some restrictions. We'll start with what we call basically 25 percent over what Medicare would allow, we'll reduce it the next year to 20 percent," which is this year, "and then by 1993 it will be down to 15 percent. You can charge 15 percent over what Medicare will allow." What have we found? We have found that a number of physicians, whether it's by accident or by design, have actually been charging the full amount, so that some patients who might be responsible for, let's say, $400 have been told by the Health Care Finance Administration, "You are now responsible for $2,900," and then they were forced to pay that and try to get the money back.

What we have found is that patients are very reluctant to question a physician's fee, and frankly we have one example of a physician saying, "If you have a problem with my fee or are challenging it, why don't you go see an attorney and take it up with my lawyer?"

Now, I'm going to ask you a question. Is this something that you can ask, let's say, an elderly patient to put the burden on them? Should the burden be on the patient to say, "Doctor, I'd like this medication or I need this medication, but I can't pay for it. Will you give me something different?" Is that something that would be within the realm, in your experience, of easily done, no problems?

Dr. HICKLER. I think what we're dealing with is a spectrum of kinds of physicians and attitudes of physicians, and I'm quite open to that. In fact, I would encourage it. And what fraction of physicians would be as open about it, I can't say. I would hope more than we would think. I think it should be proper, and I hope patients more and more are being assertive as to their rights—and I suspect they are—than in the old days when physicians were almost beyond question. I would hope so.

Mr. O'KEEFE. I think the percentage that would violate the relationship by questioning your judgment or asking you to reconsider is not that high. It might be higher than it used to be, but I'd say it's still 25 percent or under that would ever question if he says night or day.

Senator COHEN. Mr. Miller, Mr. Desjardins, are pharmacists going to be reluctant to recommend generic drugs instead of the prescribed ones?

Mr. DESJARDINS. Well, in my case, I would probably not. When I went to school in the 1970's, "generic" was almost a dirty word. But in my experience, on the whole, they've been fine. We've had a few problems here and there that tend to show up. Without the generic vehicle, the average prescription cost, which I quoted today as being $22.50, would probably be $40 or something. So I encourage it 100 percent.

Senator COHEN. You talked about something else that I want to discuss just briefly, and that is when one drug company has an increase in the price of a product, immediately all the other companies follow. It's like the airlines where American announces new discounts for flights, and now TWA is following suit. The other airlines will soon follow that. Is that something that is quite frequent within the industry itself? In other words, even a company who has not engaged in the development of a particular drug, suddenly you find the prices coincidentally all match that?

Dr. O'Keefe is nodding yes. Mr. Miller, would you comment?

I can't help but compare it to cereals and cigarettes. You'll notice that all cereals and all cigarettes and most products have price increases at the same time. However, in the drug industry, what we find is—we used to find them once a year. Then all of a sudden, it was every 6 months. Now it's almost ad libbed. A new product comes out and within 2 or 3 months, the new product that came out high is now even higher. Now, for those kinds of fluctuations, how are you going to supply Dr. Hickler with a list of drug options?

Mr. MILLER. Actually, whenever we give a price—if you call my drug store and ask for a price today, that's the price.

Senator COHEN. Okay, but now the doctor is going to say, "Do I have to call you up every day and get a price list? Every time I've got a patient coming through, I've got to get a whole rundown on all the options available? I'll just sign off on the one that I'm most familiar with." Do you have any recommendations for how you deal with this issue of the doctor and pharmacist relationship?

Dr. HICKLER. Well, I'm glad at least it's come out that there's no conspiracy between the pharmacists and doctors in general. Pharmacists have been very excellent over the years. They've been helpful and called me if something looked funny to them, et cetera. In terms of getting together on these issues, it might reduce costs, and I think that's an open field. I don't think it's done, and I would hope that pharmacies would—it's not to my benefit to have patients pay more for drugs. There's no gain in that. Whether the pharmacy industry would be open to offering the less expensive form, maybe making a slightly less profit, would you leave it to chance and hope they go for the big one, or would you want to help them? I think that's the question.

Is that fair?

Senator COHEN. This is a very unusual hearing. We rarely do this, but seeing how you present a unique opportunity to have physicians, nurses, and pharmacists all at one table with differing opinions. I'll take a few extra moments to take advantage of the situation. I'd like to explain that many people feel you all set witnesses, with all one view coming forward to say, "Beat up on the drug companies," and that clearly is not my intent. It is rather to find some solutions to a problem that's growing in criticality.

So that's why I'm doing this. I'd like to find out—because Bill Miller will come back and say, "Doctor, I'd be happy to take a little less money going generic if you will take a little less in what you're charging the patient."

Mr. MILLER. In answer to your question a long time ago, yes, we do encourage generic substitution whenever possible, and I find that the physician automatically checks the box on every single prescription he writes, and one of the people that testified before here said that the physician did that. Anamil expectorant is available generically and a lot less expensive. However, getting back to your——

Senator COHEN. Let me ask you, when the physician checks the brand name only, can you take it upon yourself at that point to change it, or do you have to call the physician and say, I've got a better drug or as good a drug at a lower price." Do you do that?

Can you change it on your own? Are you practicing medicine then? Are you able to overrule a doctor or do you need to get his permission?

Mr. MILLER. The way you're asking the question, you almost set me up. [Laughter.]

You know, if you're talking to someone that is liable to do just that. If a doctor wrote a prescription and wrote on it—I'll give you an example. If he wrote, "V-cillin K," which is Lilly's penicillin with VK, which was the original penicillin with VK, and he checked the box, I would say to you that it would be unlikely that it would ever get filled, because very few pharmacies carry V-cillin K. However, many of us carry penicillin VK by Squibb and out of some of the generic houses, and if there were a snowstorm and I was unable—I would substitute that, and I would probably wind up in a jam with the Board of Pharmacies, but I would think I could successfully defend myself. However, if he wrote a prescription for Antenode expectorant and checked the box, I would then call the physician after I discussed it with the patient and make that suggestion, and most physicians will agree with that.

Dr. HICKLER. Well, they're not being wicked; they don't know any better.

Senator COHEN. So in other words, the burden is then shifted—if the doctor, whether by advertising, whether he has been persuaded or she has been persuaded that this is a new drug with great potential, prescribes that, the burden then shifts to the pharmacist, who then calls the doctor and says, "Doctor, this patient really shouldn't have to pay that. I've got a better option," Do you do that normally?

Mr. MILLER. I do that more often than some people. If I know the patient, I know that that person doesn't have $50 in their pocket, I talk to the patient, and I will call that physician and say, "That patient does not have that much money with him. Will you change it?," and 9 out of 10 times, that physician will change it, and on the 10th time will give you a good reason to ask that patient to take the medicine.

However, the State of Maine, in its wisdom, did make it illegal for drug companies, like Tylenol with codeine, to give the doctor a bunch of blanks that say Tylenol with codeine with the blank all checked, which was being done originally. It's no longer being done in the State of Maine, because it's illegal. However, we as pharmacists today are really on the bandwagon when it comes to generic and trying to keep the price of pharmacy drugs as low as possible.

Senator COHEN. Well, I could continue this all day. Dr. O'Keefe mentioned, for example, one drug prescription that was filled in Quebec. I should point out that the prices in the United States generally run about 62 percent higher than they do in Canada. They run about 54 percent higher in the United States than they do in western Europe, and that is because they have price controls, something that we have been reluctant to do, and I think Mr. Desjardins pointed out in his testimony he feels that some of this distortion took place back in the early 1970's when we started talking about price controls. That may be the subject of some disagreement, but nonetheless I think most of the other industrialized

countries do in fact impose price controls. So it really calls into question what we're going to do with our health care system.

Dr. Hickler is quite right. We can't single out the drug industry as the sole cause of the health care crisis. It is, however, an important component and we've got to look at how we continue the kind of exploration, research and development, and tremendous opportunities that drugs in fact present for the future. At the same time we do not have a very cost effective way of treating your disease, if you can't buy it. So what we've got to do is get some balance in it, and what we're doing through this legislation is trying to get somebody's attention that we can't continue to have this kind of explosion in cost and still treat our citizens in the fashion that they deserve to be treated.

I want to thank all of you for your testimony today, and we might as well break here.

[Recess.]

Senator COHEN. Next we have Ms. Eloise Moreau, the Executive Director of Western Maine Area Agency on Aging, who's going to discuss the issues facing seniors in Maine, and Ms. Elaine Fuller, the Director of the Bureau of Medical Services, Maine Department of Human Services, who's going to discuss Maine's Low-Cost Drug Program, which I'm proud to say was one of the first programs of its kind in the country and remains 1 of only 11 operating in the country today.

Ms. Moreau.

STATEMENT OF ELOISE L. MOREAU, EXECUTIVE DIRECTOR, WESTERN AREA AGENCY ON AGING, INC.

Ms. MOREAU. My testimony will substantiate much of what we have heard this morning. The problems are very much the same. In my formal testimony, I will also be referring to what we do as an agency.

I am pleased to have the opportunity to testify this morning on an issue that our agency staff confronts on a daily basis. The continuous spiraling cost of life-sustaining drugs has made the life of persons on a fixed income a time for making choices—choices that cut across their values, reduce the effectiveness of the prescribed medication, and in general affect their ability to pay other basic necessities, such as electricity, which is also skyrocketing, rent, food, fuel, and so on.

Medicare pays only prescription drugs, as was mentioned earlier, used while in the hospital or for drugs needed the first year following an organ transplant. Here in Maine, persons may be eligible for low-cost drug cards if they meet the income guidelines of a one-person household of $8,900 or a two-person household of $11,100. The drugs covered by this program are limited to heart, diabetic, hypertension, arthritis, and chronic obstructive pulmonary disease.

In discussing my presentation with staff at our agency, I asked for examples of situations that would best describe to all of you the outrageous nature of this problem, and these are some of the stories that I was given.

A couple aged 69 and 71 and married 18 months prior to coming to our office to apply for a low-cost drug card had a combined

income of $12,800. During 1991, they spent a total of $4,000 on life-sustaining prescription drugs. They were, as a couple, $1,700 over the guidelines for the Maine program. Even residing in subsidized housing, they could not afford the medication. At this point, they were considering getting a divorce and living together so they could be eligible for assistance with their medications. This decision was in conflict with their strong values and should not even have to be considered.

A common occurrence that staff encounter as they do in-home assessments and respond to inquiries for services is the fact that many, many elderly choose to adjust their dosage to meet what they can pay for versus what the doctor has prescribed as necessary. Many will simply stop taking a drug they can't afford or reduce the dosage, taking only one-third or one-half of what has been prescribed. The end result of these choices is often more costly and involves hospitalization and other costly alternatives that the prescribed medication was meant to prevent.

Many cannot afford both their prescriptions and Medigap insurance, and so they choose to forego the insurance, again, a long-term costly decision.

Many elderly need arthritis medication. A common drug called Voltaren costs one of my staff people $86 per prescription. Her medications are presently costing approximately $250 a month and have increased 25 percent over the last 3 years. One prescription alone went from $122 in January of this year to $134 in February.

Solutions to this problem are complex and must be addressed. Our State program guidelines, Medicare, and the astronomical profits that pharmaceutical manufacturers are making all need to be addressed in order to halt this problem now, before we face the graying of America and the problem continues to accelerate out of control. I can only hope that hearings of this nature will continue to raise everyone's awareness and ultimately influence policy both on a national and State level.

At the agency, we do everything to encourage people to question their physicians, and we have also run into the same resistance that you have alluded to this morning in terms of questioning physicians. It is very, very difficult for elderly people to do. Pharmacists can help by reviewing all the various prescriptions that people take, and they do that regularly. Educational efforts are going on, and we need to make sure that everybody who is eligible for the Maine program has assistance in filling out the necessary forms in order to get on the program. Education is an ongoing process.

I thank you for the opportunity to testify.

Senator COHEN. Thank you very much, Ms. Moreau.

Ms. Fuller.

STATEMENT OF ELAINE FULLER, DIRECTOR, BUREAU OF MEDICAL SERVICES, MAINE DEPARTMENT OF HUMAN SERVICES

Ms. FULLER. Senator Cohen, I'm Elaine Fuller, Director of the Bureau of Medical Services in the Department of Human Services. This Bureau is responsible for the Medicaid Program as well as the Low-Cost Drug Program for the elderly.

As you know, OBRA-1990 included a section requiring drug rebates for any prescription drugs covered under the Medicaid program. It is my understanding that this legislation was a compromise from the original proposal to control drug costs under State Medicaid programs. The legislation that finally emerged from the negotiations included a provision that would have limited price increases for drugs. Unfortunately, that was taken out during further negotiations.

From the perspective of a Medicaid director, although well-intentioned, the Pharmacy Rebate Program has been a nightmare. While rebates have been substantial, the cost of prescription drugs has escalated in excess of any other previous year's growth. Data collected by the American Public Welfare Association, of which the State Medicaid Directors Association is a part, showed a 24-percent increase in expenditures in the first two quarters of 1991. Many of the invoiced rebates are in dispute by the drug manufacturers. As I am sure you are also aware, the cost of drugs to Federal programs, such as the Veterans Administration, has increased substantially, apparently attributable to the "best price" language in the pharmacy rebate bill, that tiered system that we were talking about earlier.

The effect of these price increases is being felt in other programs funded by State tax revenues. We do have an elderly low-cost drug program in Maine, for which the costs in the current fiscal year increased 10 percent over the initial funding request for the program. The cost of that program is projected at $4.3 million for this year. In an effort to contain costs and to be able to continue this program, which covers only certain therapeutic classes of drugs, copayments were increased from $2 for all covered drugs to $3 for single-source and generic drugs and $5 for multisource brand name drugs. There is no question that the rapidly escalating cost of drugs is jeopardizing this program.

I have information comparing drug prices in the United States to the prices of the same drugs in Canada as of May 1990. The differences range from 30 percent to 81 percent higher in the United States. I would urge that this comparison be done again.

Of serious concern is the impact of all these price increases on those who are not fortunate enough to have prescription drugs as a covered health insurance benefit. The elderly are known to be the heavy users of prescription drugs, with many on limited incomes. After discussions of the impact of the Medicaid Rebate Program on the cost of drugs, I am convinced that this program is driving up the costs to all purchasers of prescription drugs and that ultimately there will be no savings to State Medicaid programs, since the cost of the rebates will simply be offset by increases in prices, driving up costs to everyone.

I would also like to add a couple of comments about the earlier discussion on the question about what physicians know about drugs. We get an informational bulletin in our office regularly (called the Medical Letter from the Yale Medical School), and when a new drug comes out, eventually that drug is studied and a report is prepared by a group of physicians, pharmacists, et cetera, that compares the prices to similar products and compares the effectiveness of the drug to similar products.

Senator COHEN. Is this report sort of a Consumer Report?

Ms. FULLER. It could be for consumers, but it's distributed toward organizations like myself, and the medical and pharmaceutical profession. It's not a consumer report.

Senator COHEN. I know, but as far as the experts in the field, it goes to you and those in charge of various programs, but it is a comparative analysis of what the drug costs.

Ms. FULLER. It is specific to a drug itself that comes out. It's not an across-the-board kind of report.

Senator COHEN. So every time a new drug comes out——

Ms. FULLER. We get a variety of reference materials. The other pricing argument that was cited by the pharmaceutical representatives when a new drug came out to treat schizophrenia at $9,000 a year, and those of us who were having to fund it were screaming about the price, the answer was, "Yes, but how much cheaper is that than hospitalization?" I think that's not a justifiable way of pricing drugs. (This drug was available in England for less than half the price we were being charged.)

Senator COHEN. Similar to the cigarette patch thing.

Ms. FULLER. Yes, similar to the patch thing. That's why I raised it, because I heard about the patch, and it's the same kind of answer. "Well, it's much cheaper than hospitalization." Granted, it's much cheaper than hospitalization, but we can't price our drugs based on what it would cost to be in the hospital.

Thank you for this opportunity to comment. I'll be glad to answer any questions.

Senator COHEN. Thank you both for being so patient. I went way over the time allocated, but I couldn't pass up the opportunity to see what the pharmacists might say to the physicians and vice versa.

I also want to thank Gertrude Zimmerman and Lillian Trumble, who have remained in the audience, for taking time out of your day to come here and sit through the proceedings. I hope those chairs are fairly soft for you. [Laughter.]

There are a couple of other things I should say. Mary Gerwin and Tracy Gay of my staff, who had the responsibility for putting the material together, deserve a lot of credit, because they've been reading all of the thousands of letters I've received.

Ms. Moreau, you mentioned education. The fact is that none of us has the answer. I don't have the answer. I had a reporter who came up during the break at the Lewiston paper, and he said, "Well, is it really fair to compare our costs to Canada?," and the answer is, "Well, not really, because they've got a different system up there." But, they have a different kind of health care system in Canada, and frankly I don't think it's one that we should readily adopt in the United States. We talked about it, and there are some pros and cons, but it's not likely that we're going to adopt that system in the foreseeable future for the United States. And they do have different pricing. Cigarettes, I think, are $7 or $8 for a pack, and that's mostly tax in order to pay for their social programs.

But the reason I mentioned the price in Canada was because they do impose price controls, and we have no controls in the United States, and I'm not advocating that we should. But the reason is that the prices are unlimited here, and as a result of

being unlimited, we are in fact helping to subsidize lower prices in other countries. They're getting a better deal because their governments impose prices. We don't impose them, so we pay extra costs. So as a result of that, I think American citizens are in fact bearing a bigger burden in order to continue with research and development and marketing, and that's the only reason I made the comparison between the United States and other countries. We don't have price controls and we aren't likely to have them, unless things get so totally out of control that we finally have a President come in, as Richard Nixon came in back in the early 1970's and imposed price controls.

I have a question on the Medigap insurance. That's been one solution offered by drug companies. They say, "Look, don't blame us. Let's get some coverage here. If we have coverage, that will take care of costs as far as the senior citizen is concerned." Here's the catch-22. If we simply shift the cost to insurance companies, they're going to raise the premiums so high that no one will be able to buy the insurance. So that isn't going to work.

Ms. MOREAU. That's basically what my staff is saying, that in terms of Medigap insurance, I think there's one policy that is going to be made available and is probably available right now that is simply too costly for most to even consider.

Senator COHEN. Or the insurance companies say let the Federal Government pay for the cost of the drugs, and there is no control or restraint on the increase. If you say that, then who is going to pick that up? The taxpayer. Well, the taxpayer right now is faced with $400 billion cuts and a $200 billion payment on the interest. That's $200 billion going down a dark hole. So you can't say just let the taxpayers pay for the increase in price, because there isn't enough money to go around.

So what we're trying to do is struggle and find a way to say, can we in fact send a signal to the drug industry as such that, yes, you are entitled by law to increase your prices and we don't intervene in terms of what the basis of your price is, whether it's the patch test or something else, it's cheaper than being hospitalized, but we can't ask them on the other hand to continue with subsidies.

As a result, I might tell you that some pharmaceutical manufacturers have announced, for this year at least, they're going to hold their price increases to the rate of inflation. Now, that's for this year. Other companies have yet to follow, and it may not take place next year. They might go with 2 or 3 or 4 percent, and that may be little, but when we're seeing something that cost $20 in 1980 go to $120 by the year 2000, when you translate that into all the other medications, there's no way in the world people can pay for it.

We have one proposal. It may not be the best solution. There may be other approaches. All we're trying to do is go through this hearing process and find out from the people who are most directly impacted, the people who have been on the front lines, including yourselves, Bill Miller and Mr. Desjardins, among others, and the doctors, who really are not experts in that field. They are told they have a new drug, they prescribe it, but they're unaware and don't take the time and they don't have the time to be aware.

So we're going to start this dialog here today, this education, educating our senior citizens that they've got to ask—it may be uncomfortable, but if they really can't afford it, they better ask their doctor whether he can prescribe something different, or go to the pharmacist and ask if there's a better option and have the pharmacist call.

Anyway, I thank all of you for coming. It's been very beneficial to me.

[Whereupon, at 12:33 p.m., the Committee adjourned, to reconvene at the call of the Chair.]

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